STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014271	A. BUILDING: _____ B. WING _____	R-C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORTS OF HOME HUDSON II	805 HEGGEN ST HUDSON, WI 54016

(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 01/30/2024, Surveyors conducted two complaint investigations, a verification visit, and standard survey at Comforts of Home Hudson II. Data was collected through 03/07/2024. Three of 3 complaints were substantiated. Fourteen deficiencies were identified. Four of 14 deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) 92G311, dated 9/1/2021; 92G312, dated 5/2/2022; and 92G314, dated 7/11/2023. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 31	{N 000}		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written report was sent to the department within 3 working days after law enforcement personnel was called to the CBRF	N 164		

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

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N 164	Continued From page 1	N 164		

(community based residential facility) for incidents that jeopardized the health, safety, or welfare of residents or employees.

Findings include:

This provider is licensed to serve up to 40 residents in the client groups: physically disabled, advanced aged, and irreversible dementia/Alzheimer's.

On 01/30/2024, Surveyor requested to review Resident 4's record, including observation notes and physician communication notes.

Resident 4 had an admission date of 11/07/2023. On 01/30/2024 at approximately 6:15 PM, Quality Assurance/Float House Manager (QA/FHM) B provided physician communication notes and stated, "[Resident 4] went out yesterday for behavioral type incident. [Regional Director (RD) C] states they don't have bleach here so not sure why they (staff) wrote that."

On 01/31/2024, Surveyor retrieved the following staff charting and observation progress notes from the facility's electronic record system:

-2/1/2024 at 15:46 Note Text: Around 4:40 resident pull [sic] the fire alarm and left the building staff try to stop [him/her] but was no [sic] possible, staff called the Police to make the report. Management notified. At 5:10 resident was found by the police and brought back. The fire chief was here to fix the alarm.

-2/1/2024 at 15:46 Note Text: At 5:45am resident pull [sic] the fire alarm again and left the building. the [sic] police had to be called again. The fire department was here as well. They want

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N 164	Continued From page 2	N 164		

management to take care of this. Management notified.

-2/1/2024 at 15:44 Note Text: At 1:40am, staff had to call the Police on said resident, when staff were cleaning the tables with the Q3 (cleaning agent/toxic substance), [Resident 4] took the bottle and poured it in 14's cup and told [him/her] [s/he] had to drink it because it would clean [his/her] system and make [him/her] smarter convincing 14 to drink.

-2/1/2024 at 15:44 Note Text: Continue... [Resident 4] refused to give back the Q3 bottle, [sic] [s/he] told [Resident 3] that she would give it to [him/her] later. Police arrived at the building and couldn't take [him/her] because they didn't have enough reason take [him/her] in and [s/he] already has depression and anxiety problems since [s/he] was admitted here.

-1/29/2024 at 10:50 Note Text: Resident has had behaviors that are not normal for the past 5-6 days. Resident has threatened to stab staff with sharp objects. The resident has pulled the fire alarm multiple times and pushed [his/her] way through the door to get out of the facility, [sic] Staff hadto [sic] go after [him/her] and [s/he] swung to hit staff. Resident is talking about things that are not really here [sic]. [S/he] is stating that [s/he] wants to die and [s/he] wants to be with [his/her] soulmate that has died. Staff had called 911 to try and get [him/her] some help and they refused to take [him/her] in. As soon as the police left [his/her] behavior's [sic] started again. The resident is really struggling with [his/her] mental health and has been a danger to [him/herself] and others.

-1/28/2024 at 11:06 Note Text: On 01/27 resident

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N 164	Continued From page 3 was experiencing suicidal behaviors and was a threat to [him/herself] and other [sic] resident. [sic] police and EMT were contacted and refused to take [him/her] into the Emergency Department (ED) to be evaluated. Resident is still residing at [facility name]. [Managed Care Organization (MCO)] informed about resident behaviors and refusal of transport to ED and stated they would follow up on Tuesday 01/30/24. On 02/15/2024 at approximately 10:00 AM, Surveyor interviewed Administrator A and QA/FHM B and asked if the above incidents where police were called to the facility were reported to the Department. Administrator A stated, "We do call the police when we are sending the residents in. So [sic] typically that's who we would contact EMS (emergency medical services) to come to the facility. Contacted 911 and they dispatched EMTs (emergency medical technicians) to come. Over the weekend, yes, [s/he] didn't actually get off of the premises." Administrator A further stated s/he was not aware of the requirement to report when law enforcement was called for an incident that jeopardized the health, safety and welfare of residents or employees. Cross Reference N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0433 DHS 83.38(1)(i) Behavior Management	N 164		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the	N 165		

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N 165	Continued From page 4 following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the Department was notified within 3 working days when Resident 8 fell and received emergency room treatment on 01/25/2024. Findings include: On 01/30/2024, the provider reviewed Resident 8's record. An incident report dated 01/25/2024 at 2:30 AM, stated, "Resident was calling for help and staff found [him/her] laying [sic] down on the floor by [his/her] bed." The incident report included an image of a person with directions to "please note location/type of injury." Staff circled the chin/mouth area and top of the right hand. The second page of the report read, "Describe injury and directions given to staff to care for resident: Injury noted, staff to change dressing on right hand once a day and as needed." The report indicated Resident 8 was taken to the hospital at 3:30 AM and returned at 6:30 AM. Surveyor reviewed Resident 8's progress notes. On 01/29/2024 at 12:55 PM, Administrator A wrote, "[Resident 8] was seen in the ED [emergency department] on 01/25/24 due to a fall resulting in a skin tear on [his/her] right hand and forearm. Discharged same day with orders to change dressing once a day and as needed. Apply Vaseline to area if bleeding continues. Monitor sore until healed. ISP [individual service	N 165		

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N 165	Continued From page 5 plan] updated with ADLS [activities of daily living services] and mobility for transferring." On 01/30/2024 at approximately 12:00 PM, Surveyor interviewed Resident 8's Health Care Power of Attorney (HCPOA), HCPOA T. HCPOA T stated, "I'm here cleaning out some boxes since [Resident 8] is at the hospital and being moved to [another facility name]. The doctors felt [s/he] needed additional nursing care. [S/he] went in last Friday. [S/he] actually fell Thursday (the day before) at 2:00 AM, went in and got [his/her] lip stitched up and got [his/her] hand re-bandaged, came back (to the facility) Thursday, and then went back to the ER (emergency room) Friday because [his/her] hand wouldn't stop bleeding." On 01/31/2024 at 11:41 AM, Surveyor received a self-report from Administrator A, notifying the Department of the fall that occurred on 01/25/2024 at 2:30 AM. Injuries included a skin tear on his/her right hand and upper lip. The report read, "[S/he] discharged back to the facility the same day with absorbable stitches to the laceration on [his/her] lip, and the skin tear on [his/her] right hand was cleaned and covered." The provider notified the Department 5 business days after Resident 8's incident.	N 165		
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.	N 196		

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N 196	Continued From page 6 This Rule is not met as evidenced by: Based on observation, interview, and record review, the licensee did not ensure the community-based residential facility (CBRF) and its operation complied with all laws and regulations. Findings include: This provider is licensed to serve up to 40 residents in the client groups physically disabled, advanced aged, and irreversible dementia/Alzheimer's disease. In the prior 6 years, the Department has substantiated 5 complaints related to program services, staff training/proficiency, and resident rights at the provider's facility. Five surveys have resulted in enforcement action, including a total of $3800 in forfeitures, orders to comply with regulations, and special orders. The current survey was prompted by 3 complaints and a verification visit to ensure compliance was achieved after violations were issued during a previous survey. The verification visit was the provider's 4th consecutive verification visit for a survey series that began in 2021. See Statement of Deficiency (SOD) 92G311, dated 11/17/2021. The Department conducted 4 verification visits after SOD 92G311, and found the provider did not achieve or maintain compliance with the regulations each time. The current survey resulted in 3 substantiated complaints. The following issues were identified throughout the survey process: - The provider did not notify the Department when law enforcement was called to the facility due to	N 196		

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N 196	Continued From page 7 health/safety/welfare concerns. - The provider did not notify the Department within 3 business days of incidents resulting in serious injury. - Staff training was not completed per requirements. This was a repeat violation; see SOD 92G312, dated 5/2/2022. - The provider did not provide notice to residents prior to discharge. - Staff did not administer resident medications per physician's orders or standards of practice. - The provider did not adequately assess residents prior to or after admission. This was a repeat violation; see SOD 92G312, dated 5/2/2022. - Service plans were not updated or accurate to resident needs and services. This was a repeat violation. See SOD 92G311, dated 9/1/2021; SOD 92G312, dated 5/2/2022; and SOD 92G314, dated 7/11/2023. - The provider did not monitor resident health and arrange for health services timely. This was a repeat violation; see SOD 92G311, dated 9/1/2021. - Residents with harmful behavior patterns did not have behavior management services. - The provider did not follow internal infection control policies or the industry standards to prevent the spread of communicable disease. - Staff did not practice adequate hand hygiene. - Out of state criminal history checks were not completed. Cross references: N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called N0165 DHS 83.12(4)(c) Reporting Incidents With Serious Injury N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses	N 196		

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N 196	Continued From page 8 N0328 DHS 83.31(4)(c) Involuntary Discharge Notice Requirements N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0431 DHS 83.38(1)(g) Health Monitoring N0432 DHS 83.38(1)(h) Medication Administration N0433 DHS 83.38(1)(i) Behavior Management N0439 DHS 83.39(1) Infection Control Program N0441 DHS 83.39(3) Hand Washing Z0012 Wis. Stat. ch 50.065(2)(bm) Out Of State Background Checks	N 196		
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 employee who manages, administers or assists residents with prescribed or over-the-counter	N 239		

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N 239	Continued From page 9 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 2 of 4 employees obtained all department approved training as required. Caregiver D and Caregiver E did not have training in fire safety within 90 days after starting employment. Caregiver D and Caregiver E did not have training in first aid and choking within 90 days after starting employment. This is a repeat violation. See Statement of Deficiency (SOD) 92G312, dated 5/2/2022. Findings include: On 01/30/2024, Surveyor conducted a review of 4 employees to verify compliance with department approved training requirements. FIRE SAFETY Caregiver D had a hire date of 09/13/2023. The record did not contain evidence Caregiver D completed training in fire safety. Caregiver E had a hire date of 11/14/2023. The record did not contain evidence Caregiver D completed training in fire safety.	N 239		

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N 239	Continued From page 10 On 01/30/2024, Surveyor verified Caregiver D was not on the Community-Based Care and Treatment training registry for fire safety. On 02/13/2024, Surveyor verified Caregiver E was not on the Community-Based Care and Treatment training registry for fire safety. (Caregiver E should have received training in Fire Safety by 02/12/2024). FIRST AID Caregiver D had a hire date of 09/13/2023. The record did not contain evidence Caregiver D completed training in first aid and choking. Caregiver E had a hire date of 11/14/2023. The record did not contain evidence Caregiver E completed training in first aid and choking. On 01/30/2024, Surveyor verified Caregiver D was not on the Community-Based Care and Treatment training registry for first aid and choking. On 02/13/2024, Surveyor verified Caregiver E was not on the Community-Based Care and Treatment training registry for first aid and choking. (Caregiver E should have received training in First Aid and Choking by 02/12/2024). INTERVIEW On 01/30/2024 at 2:58 PM, Surveyor was informed by Quality Assurance/Float House Manager (QA/FHM) B that Caregiver D and Caregiver E had taken the classes and stated s/he would have the rosters. QA/FHM B was not sure why they were not on the registry. Administrator A stated s/he had signed off that they received the classes and informed Surveyor Caregiver D and Caregiver E had taken both	N 239		

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N 239	Continued From page 11 classes. On 02/01/2024 at 2:49 PM, Surveyor received an email from QA/FHM B that read, in part, "The instructors do not have a class roster for either [Caregiver E] or [Caregiver D] for Fire Safety or First Aid and Choking. [Administrator A] will be signing them up for the next scheduled classes. On 02/15/2024 at approximately 10:00 AM, Surveyor interviewed Administrator A and QA/FHM B and asked if Caregiver D and Caregiver E had been scheduled for Fire Safety and first aid and choking. QA/FHM B stated Caregiver D and Caregiver E completed training in Fire Safety and First Aid and Choking on 02/14/2024. Surveyor discussed the concern that Caregiver D and Caregiver E did not receive training within 90 days of the start of employment. Caregiver E should have completed Fire Safety and First Aid by 02/12/2024. QA/FHM B confirmed Caregiver D and Caregiver E did not meet an exemption for fire safety or first aid and choking. The provider did not ensure department approved training was completed for fire safety and first aid and choking within 90 days of employment for Caregiver D and Caregiver E.	N 239		
N 328	83.31(4)(c) Involuntary discharge notice requirements. Discharge or transfer initiated by CBRF. Notice requirements. Every notice of involuntary discharge shall be in writing to the resident or	N 328		

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N 328	Continued From page 12 resident ' s legal representative and shall include all of the following: 1. A statement setting forth the reason and justification for discharge listed under par. (b). 2. A statement that the resident or the resident ' s legal representative may ask the department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the department ' s regional office with a copy to the CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place. 3. The name, address and telephone number of the department ' s regional office director. 4. The name, address and telephone number of the regional office of the board on aging and long term care ' s ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy agency designated under s. 51.62(2)(a), Stats. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 9 received an involuntary discharge notice 30 days prior to discharge. Resident 9 was sent to the emergency department on 12/22/2023 for medical assessment and treatment of a hand injury and the provider immediately discharged Resident 9 due to his/her behavior. Findings include: The provider is licensed to care for 40 residents in the client groups advanced aged, physically disabled, and irreversible dementia/Alzheimer's disease.	N 328		

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N 328	Continued From page 13 On 01/02/2024, the Department received a complaint regarding the provider's discharge procedures. Between 01/02/2024 and 01/30/2024, the Department received information from St. Croix County related to Resident 9's discharge. The information included the following: - A letter, dated 12/22/2023, from St. Croix County Corporation Counsel to the provider that read, in part: "[Resident 9] was placed, under and Emergency Protective Placement, at Comforts of Home on December 15, 2023. On today's date, my office has learned that [s/he] suffered a hand injury that included fractures, on December 16, 2023. To get treatment for this hand injury, [s/he] was transported, via ambulance to local [sic] hospital. [S/he] was then discharged by your facility." - An emergency department visit note, electronically signed by the attending physician on 12/22/2023 at 5:35 PM, indicating Resident 9 was brought in for "evaluation of left hand and wrist pain and swelling" at 11:57 AM. The physician wrote at 12:26 PM, "...[Provider] called and patient had been in their assisted living side although on my assessment [s/he] should have been in their memory care facility if [s/he] was on a chapter 55 prior. [Provider] saying [s/he] is not allowed to come back to their assisted living side. County social worker is now involved." - The provider's discharge form, signed by Assistant Manager (AM) L on 12/22/2023, indicating Resident 9's reason for discharge was "mental health stay." The discharge form identified Social Worker (SW) M as Resident 9's	N 328		

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N 328	Continued From page 14 "State Guardian." On 01/10/2024 at 8:22 AM, Surveyor interviewed SW M. SW M stated s/he was not Resident 9's guardian. SW M stated s/he was involved due to Resident 9's protective placement order for Resident 9's placement at the facility on 12/15/2023. SW M stated Resident 9 fell on 12/16/2023, but s/he was not informed of the fall until 12/20/2023. SW M stated s/he visited Resident 9 on 12/21/2023, assuming the fall occurred on 12/20/2023. SW M said Resident 9's wrist was obviously injured. SW M stated s/he met with Administrator A before s/he left on 12/21/2023, and Administrator A asked if Resident 9 could leave the facility for medical treatment due to his/her protective placement order. SW M stated s/he educated Administrator A that Resident 9 could and should seek medical treatment for his/her hand. On 12/22/2023, SW M called Administrator A to get an update on Resident 9's hand. SW M stated, "[Administrator A] said if [Resident 9] left the grounds [s/he] would be discharged. I said, 'What?!' [Administrator A] also told me if we wanted [Resident 9] to return to the facility, [s/he] would have to be re-referred and that [s/he] wouldn't likely be accepted back...I reiterated over and over, 'So you're telling me [s/he] will be discharged?' [Administrator A] kept confirming that was correct." SW M stated s/he directed Administrator A to call 911 and have Resident 9 transferred to the emergency room (ER) to get medical attention for his/her hand. SW M stated s/he ended the call with Administrator A and called Hudson Hospital and let them know Resident 9 would be coming. While at the hospital, SW M got a call from an ER nurse asking if s/he felt the provider would be	N 328		

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N 328	Continued From page 15 able to manage keeping Resident 9 in a cast. SW M stated s/he informed the ER nurse that the provider said Resident 9 could not return. SW M stated the nurse called the provider and received confirmation that Resident 9 had been discharged from their facility. On 01/30/2024 and 01/31/2024, Surveyor reviewed Resident 9's record. Resident 9 was admitted to the facility on 12/15/2023 and discharged 12/22/2023. His/her diagnoses included age-related cognitive decline and generalized anxiety disorder. According to an incident report dated 12/16/2023, Resident 9 fell and injured his/her wrist during an attempted elopement. An x-ray summary of the injured wrist dated 12/21/2023 identified the following: "Fracture of the 3rd metacarpal and possibly the 4th metacarpal without significant displacement. There is soft tissue swelling." On 02/15/2024 at approximately 11:30 AM, Surveyor interviewed Administrator A and Quality Assurance/Float House Manager (QA/FHM) B. Surveyor asked who initiated Resident 9's discharge. Administrator A stated, "We discharged [him/her] after [s/he] went to the hospital due to behavior." Surveyor asked if the provider issued a written notice to Resident 9 or his/her legal representative. Administrator A stated they did not. Administrator A denied prohibiting Resident 9 from seeking outside medical attention for his/her hand but stated, "It was communicated to the social worker that if [Resident 9] left, s/he would not be coming back." Cross references: N0431 DHS 83.38(1)(g) Health Monitoring N0433 DHS 83.38(1)(i) Behavior Management	N 328		

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N 352	Continued From page 16	N 352		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure Resident 1 and Resident 14 received medication in the dosage and intervals prescribed by the practitioner. Findings include: On 11/14/2023, the Department received a complaint regarding resident care. This facility is licensed to serve up to 40 residents in the client groups: physically disabled, advanced aged, and irreversible dementia/Alzheimer's disease. On 01/30/2024 at 9:52 AM, Surveyor observed the 8:00 AM medication pass with Caregiver F. Caregiver F stated s/he was running late on the medication pass because s/he was called in to work after the caregiver scheduled for the shift called in and did not show up. RESIDENT 1 On 01/30/2024 at 10:00 AM, Caregiver F entered Resident 1's room and administered 1 drop of Sodium Chloride 5% into both eyes. Caregiver F	N 352		

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N 352	Continued From page 17 administered Refresh Tears into both eyes approximately 45 seconds after the Sodium Chloride drops. Caregiver F placed both bottles back into a container, labeled with the prescription. The label on the container for Sodium Chloride read, "Instill one drop in the left eye three times daily at 8AM, 2PM & 8PM." The label for Refresh Tears 0.5% read, "Instill 1 drop into left eye 3 times a day at 8AM, 2PM & 8PM." Surveyor asked Caregiver F if s/he administered the Sodium Chloride and Refresh Tears into both eyes. Caregiver F stated, "Yes, I did." Caregiver F read the label for both drops administered and informed Surveyor s/he did not read the labels and did not administer the drops as prescribed. On 01/30/2024 at 10:03 AM, Caregiver F further stated, "I don't normally work this shift (morning), I work PM's (evenings) and I got called back in this morning because someone called in. I worked last night and stayed up way too late and I'm running on 2 hours of sleep. I would be going faster but I don't do morning meds (medications) & have to look up who gets blood pressures and stuff. I'm supposed to be done by 9:00 (AM) but at least I'm getting them done. I didn't get here until about 7:30 (AM) to start. I know I'm behind schedule." Caregiver F informed Surveyor s/he had 2 more residents to administer medications to before the morning medication pass was complete. At approximately 4:30 PM, Surveyor observed Caregiver F was still in the facility and asked if s/he was working the evening shift. Caregiver F stated, "Yep, I'm working a double, but I went and took a nap at my friend's house so I'm good."	N 352		

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N 352	Continued From page 18 Caregiver F was also the designated med passer for the evening shift. RESIDENT 14 On 02/07/2024, Surveyor requested to review Resident 14's record, including but not limited to, the individual service plan (ISP), health concerns/changes in condition documentation, staff charting notes, task administration record (TAR), medication administration record (MAR) and discharge information. Resident 14 had an admission date of 10/25/2022 and had the following medical conditions: chronic obstructive pulmonary disease with acute exacerbation, and essential primary hypertension. Resident 14 was discharged from the facility on 11/03/2023. A document with the title, "DISCHARGE FORM" stated the reason for discharge was "needed more cares." Surveyor reviewed Resident 14's MAR for September, October, and November 2023. The September MAR showed Resident 14 had an order for Spiriva Respimat Aerosol Solution 2.5 MCG/ACT with instructions for "2 puff inhale orally at bedtime for COPD (chronic obstructive pulmonary disease)." The MAR showed Resident 14 did not receive this medication as ordered on 09/23/2023, 09/24/2023, and 09/25/2023, with a documentation code that corresponded to "Medication is NOT in the facility." On 02/20/2024, Surveyor emailed Administrator A and QA/FHM B and asked if Resident 14's physician was notified of the missed doses. Administrator A replied and stated they were not	N 352		

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N 352	Continued From page 19 able to verify that as they did not have access to the portal. Resident 14 did not receive Spiriva for three consecutive days as it was not available to administer as ordered. Cross Reference N0431 DHS 83.38(1)(g) Health Monitoring N0432 DHS 83.38(1)(h) Medication Administration N0441 DHS 83.39(3) Hand Washing	N 352		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not assess Resident 4's behaviors prior to admission when Resident 4 exhibited significant behaviors requiring intervention. The provider was not prepared to manage behaviors when Resident 4 was a danger to him/herself and others.	N 381		

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N 381	Continued From page 20 This is a repeat violation. See Statement of Deficiency (SOD) 92G312, dated 5/2/2022. Findings include: On 01/30/2024, Surveyor requested to review Resident 4's record. Resident 4 had an admission date of 11/07/2023. The face sheet showed Resident 4 had the following diagnoses related to behavior: bipolar disorder, poisoning by methamphetamines, other long term (current) drug therapy, panic disorder. On 01/30/2024, Surveyor reviewed staff charting notes for Resident 4 since admission. The charting notes identified significant behaviors that required intervention: depression, suicidal ideation, paranoia, anxiety, contacting the police for assistance, coaxing another resident into self-harm, threatening bodily harm to staff, stealing items from another resident's room, pulling the fire alarm, elopement from the facility, and wandering/exit seeking. Charting notes documented staff contacted the police and emergency medical technicians (EMTs) to assist with the above behaviors. Surveyor reviewed the pre-admission assessment for Resident 4, dated 11/01/2023. The behavior section read: -Wandering (left blank) -Sleep Disturbances (left blank) -Confused (left blank -Depressed: yes [sic] spends a lot of time alone and may cry -Withdrawn/decreased socialization: (left blank) -Agitation (left blank)	N 381		

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N 381	Continued From page 21 -Anxiety: very nervous -Current behaviors and management (left blank) Surveyor reviewed the document, "History and Physical" (H&P) in Resident 4's record, dated 10/09/2023. The H&P read, in part, "Patient is a [age] [gender] with past medical history significant for bipolar disorder, chronic kidney disease stage III, essential hypertension, polysubstance abuse, hyperlipidemia, rheumatoid arthritis, cognitive impairment, and anxiety with panic disorder who presented to outside emergency department after being found down at home. Patient is a poor historian therefore HPI is somewhat difficult to obtain.... Denies any alcohol use but does endorse methamphetamine usage with last known use a few days ago." The H&P further read, "On admission patient scored positively for past history of suicidal ideation with attempt, will continue suicide precautions while inpatient." On 02/01/2024 at 2:41 PM, Surveyor received an email from Quality Assurance/Float House Manager (QA/FHM) B that read, "Attached is [Resident 4]'s Temporary Service Plan and H&P from prior to admission. The facility was communicating with [social worker] at the Senior Living [sic] [s/he] was previously residing at. We do not have a signed Service Plan; however, I did attach [his/her] current Service Plan." Surveyor reviewed the temporary service plan received from QA/FHM B. The temporary ISP did not address or identify any behaviors. On 02/01/2024 at 3:52 PM, Surveyor received an email from QA/FHM B that read, "[Resident 4]'s assessment was completed via zoom prior to my admission from my understanding. [S/he] does not have any incident reports."	N 381		

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N 381	Continued From page 22 No incident reports were available for review for Resident 4 regarding his/her aggressive/self-harm behaviors. INTERVIEW On 02/15/2024 at approximately 10:00 AM, Surveyor interviewed Administrator A and QA/FHM B about Resident 4's admission. Administrator A stated s/he did not complete the pre-admission assessment for Resident 4. QA/FHM B reviewed the pre-admission assessment in the record and stated, "[Person J] was doing admissions at that time. [S/he] no longer works here. [S/he] would do the assessment and relay that (information) on to management." Administrator A stated s/he was not aware Resident 4 had behaviors prior to or upon admission and further stated, "I found that out when [s/he] moved to our facility." Surveyor asked what sources were used for the pre-admission assessment. QA/FHM B stated Person J completed the pre-admission form and H&P from the facility Resident 4 was at prior to his/her admission, and reviewed the member centered plan (MCP) report from the managed care organization (MCO). Surveyor asked if Person J was still in charge of admissions. QA/FHM B stated Person J was no longer employed at the provider and informed Surveyor the administrator was responsible for completing the pre-admission assessment for all residents admitted to the facility. Resident 4 was not properly assessed prior to admission when the H&P obtained by the provider identified Resident 4 had bipolar	N 381		

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N 381	Continued From page 23 disorder, anxiety, paranoia, and a history of suicidal ideations. The provider reported they were not aware of Resident 4's behaviors until s/he was admitted to the facility and was not prepared to manage behaviors. Cross Reference N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called 0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes 0433 DHS 83.38 (1)(i) Behavior Management	N 381		
{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure individual service plans (ISP) were updated to meet the needs of residents, for 3 residents sampled. Resident 3's ISP was not updated when s/he experienced a change in condition that required additional	{N 389}		

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{N 389}	Continued From page 24 monitoring or changes to his/her transfer needs. Resident 4's ISP did not include interventions or services to address harmful behaviors. Resident 7's ISP was not updated to include behavioral approaches or changes to his/her diet. This is a repeat violation. See Statement of Deficiency (SOD) 92G311, dated 9/1/2021; SOD 92G312, dated 5/2/2022; and SOD 92G314, dated 7/11/2023. Findings include: On 08/18/2023, the Department issued special orders with SOD 92G314, that read: "Pursuant to Wis. Stat. §§ 50.03(5g)(b)3. and (b)6., effective immediately, the licensee shall comply with the requirements specified by Wis. Admin. Code § DHS 83.35(3)(d). That is, the CBRF shall develop a comprehensive individual service plan, and update when there is a change in needs, abilities or condition, and at least annually based on an assessment. The licensee will develop (or review/revise) written procedures and staff training (as appropriate) to address: - An up to date, written, comprehensive assessment of all current residents, in all areas required by Wis. Admin. Code § DHS 83.35(1)(c). The assessments shall address potential safety risks associated with resident health conditions (e.g., skin injuries, choking, aggression, elopement, falls or other safety risks.), special diets, assistive devices and behaviors, and include the least restrictive measures necessary to meet the resident's needs. -The timely development, completion, and revision of Individualized Service Plan (ISP) with specific individualized interventions.	{N 389}		

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{N 389}	Continued From page 25 -The ISP review process shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or legal representative shall sign the ISP acknowledging their involvement in, understanding of, and agreement with the ISP. - All staff responsible for providing services to residents will review the resident's individualized service plan and will provide services in accordance with the plan." In January 2024, the Department received 2 complaints related to resident care and treatment. RESIDENT 3 On 01/30/2024 at 11:38 AM, Surveyor interviewed Housekeeper G, who was in the hallway near Resident 3's room. Surveyor observed a garbage can outside of Resident 3's room with a red garbage bag. Surveyor asked Housekeeper G why there was a red garbage bag in the can outside of the room. Housekeeper G stated, "We think [Resident 3] has whatever is going around and [s/he]'s going down and might die from it. The red bag and garbage can means [sic] [s/he]'s got something bad." On 01/30/2024 at 11:40 AM, Surveyor observed Resident 3's door was partially open and Resident 3 appeared to be sleeping in bed. Surveyor requested to review Resident 3's record and requested documentation related to the recent change in condition. Staff charting notes showed the following entry: 1/30/2024 14:18 Resident oxygen level was reading at 91, [sic] Hospice provided prn (as needed) oxygen at 2-6 liters. Staff to monitor for	{N 389}		

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{N 389}	Continued From page 26 change in condition. Surveyor reviewed hospice care notes in Resident 3's hospice binder which had the following entries: 01/26/2024: Pt (Patient) was a 1 assist for all Adl's [sic] (activities of daily living). Writer provided pt assistance w/transfers, toileting, repo, shampoo, shower, lotion, peri, oral, hair & incont [sic] (incontinence) care. Pt was incont [sic] of bladder. Bed linens changed, light housekeeping done, garbage & laundry out. No concerns. 01/29/2024: Pt was a 2 assist for all Adl's [sic]. Writer assisted pt w/transfer to bed from recliner, repo, dressing, peri, oral, hair & incont [sic] care. Pt was incont [sic] of bladder. Writer updated RNCM (registered nurse case manager). Light housekeeping done, garbage & laundry out. 01/30/2024: Lying in bed. nonproductive cough, agitated although just had PRN Lorazepam, refused, swatting at writer, told writer to just get out with your germs, agitation caused increase in cough [sic] so writer left. Report given to HM (house manager) [Administrator A]. On 01/30/2024 at approximately 6:10 PM, Surveyor interviewed Caregiver K and asked what Resident 3's current transfer status was for assistance. Caregiver K pulled up the task list for Resident 3 on the tablet s/he was using, which showed the following clinical alerts: 01/29/2024: Resident has a fever of 102.3 and will be guven [sic] an acetaminophen [sic] PRN to help try and bring it down a little. Staff will watch over [him/her] and continue to check [his/her] temp throughout the night.	{N 389}		

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{N 389}	Continued From page 27 01/30/2024: PRN was effective and fever has been brought down to 99.5, staff will continue to monitor. Caregiver K then informed Surveyor that Resident 3's care plan showed the following entries related to mobility: -Ambulation: Resident does not ambulate, [s/he] uses a wheelchair for all mobility. [S/he] is not able to self propel in [his/her] wheelchair, staff to assist with this. -Transfers: Staff to assist resident with all transfers -Transfers & Mobility: Resident ambulates independently with the use of a cane. May need reminders at times to use cane. Surveyor reviewed Resident 3's ISP, received on 02/01/2024. The ISP read, in part: -Transfers: [Resident 3] requires staff assistance for all transfers. Staff to assist resident with all transfers. -Transfers & Mobility: Resident ambulates independently with the use of a cane. May need reminders at times to use cane. On 02/15/2024 at approximately 10:00 AM, Surveyor interviewed Administrator A and Quality Assurance/Float House Manager (QA/FHM) B about the inconsistencies and lack of detail regarding Resident 3's transfer and mobility status. Administrator A stated, "Assuming it was around the time [s/he] was weak so staff were assisting [him/her] with 2 assist due to the weakness, because of the illness." Surveyor asked Administrator A what type of assistance	{N 389}		

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staff should be providing to Resident 3. Administrator A stated, "There is no answer, [sic] It's not in [his/her] tasks. [S/he] only needed it for a day or two. Now back to baseline. 1 assist/stand-by assist." QA/FHM B stated, "We could word it differently, so it doesn't contradict each other that [s/he] uses the wheelchair, but at times uses [his/her] cane."

Resident 3's ISP was not updated when s/he experienced a change in condition due to an illness on 01/29/2024 and required 2 staff to assist him/her with all ADLs.

RESIDENT 4

On 01/30/2024, Surveyor requested to review Resident 4's record. Resident 4 had an admission date of 11/07/2023.

The face sheet showed Resident 4 had the following diagnoses related to behavior: bipolar disorder, poisoning by methamphetamines, other long term (current) drug therapy, panic disorder.

On 01/30/2024, Surveyor reviewed staff charting notes for Resident 4 since admission. The charting notes identified significant behaviors that required intervention: depression, suicidal ideation, paranoia, anxiety, contacting the police for assistance, coaxing another resident into self-harm, threatening bodily harm to staff, stealing items from another resident's room, pulling the fire alarm, elopement from the facility, and wandering/exit seeking.

Charting notes documented staff contacted the police and emergency medical technicians (EMTs) to assist with the above behaviors on multiple occasions.

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{N 389}	Continued From page 29 On 02/01/2024 at 2:41 PM, Surveyor received an email from Quality Assurance/Float House Manager (QA/FHM) B that read, "Attached is [Resident 4]'s Temporary Service Plan and H&P from prior to admission. The facility was communicating with [social worker] at the Senior Living [sic] [s/he] was previously residing at. We do not have a signed Service Plan; however, I did attach [his/her] current Service Plan." Surveyor reviewed the temporary service plan received from QA/FHM B. The temporary ISP did not address or identify any behaviors. Surveyor reviewed the ISP provided by QA/FHM B. The ISP showed the following information: -Psychotropic medications: See EMar (electronic medication administration record) Remain compliant with taking psychotropic medications. See medication list for all psychotropic medications. Staff will continue to administer medication as ordered. Staff will update management with changes or concerns. -Supervision: Resident will receive 24 hour [sic] supervision within the facility. Facility to provide 24 hour [sic] supervision. -Elopement risk: Resident is a [sic] elopement risk. Safety will be maintained. Triggers for wandering/eloping are when s/he is struggling with [his/her] mental health. Will monitor for changes. -Safety: To be safe while living in community. Safety check [sic] every 2 hours. -Behaviors anxiety, cognitive changes, depression. Will not act out in a way that is harmful to self or others. Staff to ensure behaviors are stable and alert with changes. Monitor behaviors: Facility staff will monitor any [sic] and all the [sic] resident's behaviors and	{N 389}		

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document appropriately.
-Mental health status of resident. Resident keeps to themselves the majority of the time. Staff will monitor resident for any changes.

The ISP did not address behaviors or crisis support utilized for Resident 4 when s/he experienced episodes requiring police and EMS to be notified with request for assistance. The ISP did not direct staff to what behaviors specifically Resident 4 exhibited and did not identify interventions or approaches for staff to utilize to assist in managing Resident 4's behaviors related to his/her bipolar disorder.

The ISP was not signed or dated, indicating acknowledgement and involvement with the plan.

On 02/15/2025, at approximately 10:00 AM, Surveyor interviewed Administrator A and QA/FHM B. Surveyor asked how the provider managed Resident 4's behaviors and what the expectation was for staff to manage behaviors when it was not listed in the ISP. Administrator A stated, "We provide a temp (temporary) ISP for staff review. Tasks are added in on [his/her] care plan. Tasks flow to point click care (electronic charting system) app (application) on the Ipad for charting. The TAR (treatment administration record) they are signing off for that." Administrator A reviewed Resident 4's ISP and further stated, "There would have been communication notes when behaviors were occurring. It's not in her ISP."

Resident 4's ISP was not updated when Resident 4 exhibited behaviors related to suicidal ideation and harm to others and did not specify interventions for staff to manage ongoing behaviors. The ISP was not signed by Resident 4

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{N 389}	Continued From page 31 or Resident 4's legal representative. RESIDENT 7 Between 01/30/2024 and 02/01/2024, Surveyor reviewed Resident 7's record. Records were obtained from the provider directly on 01/30/2024 and 01/31/2023, the St. Croix police department on 01/31/2024, and the provider's electronic charting system on 02/01/2024. Resident 7 was admitted to the facility on 05/04/2023 and discharged to the hospital on 01/07/2024. According to a comprehensive medical assessment completed on 02/14/2023, Resident 7 had an extensive list of diagnoses that included the following: - Major depressive disorder, severe, recurrent, with psychotic symptoms - Recurrent urinary tract infections - Kidney disease, stage 3 - COPD (chronic obstructive pulmonary disease) - Chronic pain syndrome (related to osteoarthritis, degenerative disc disease, and spinal stenosis) - GERD (gastroesophageal reflux disease) Resident 7's medication and treatment orders, dated 04/25/2023, included an order for "weigh weekly before breakfast." According to the comprehensive medical assessment referenced above, this order had been in place since 2020 due to Resident 7's congestive heart failure and obesity diagnoses. According to Resident 7's vital history, Resident 7's weight on 05/05/2023 (day after admission) was 261 lbs. On 08/22/2023, Resident 7 was 205.8 lbs. Resident 7's record included a signed	{N 389}		

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physician order for Ensure twice daily with meals, dated 08/22/2023. On 12/27/2023, in response to additional weight loss and concerns of poor nutrition due to frequent meal refusals, Resident 7's physician prescribed Ensure 3 times daily with meals.

According to Resident 7's medical record (i.e., Bridge communication portal), s/he was referred to behavioral health on 05/17/2023. Resident 7's behavioral health therapist relayed the following recommendation to the provider throughout Resident 7's placement:

- 06/29/2023: "Continues to refuse cares on a regular basis. [S/he] is very independent-minded and likes to do things [him/herself]. I got the impression [s/he] didn't like it when care staff are overly helpful (e.g. 'Can I help you with ___') [s/he] will almost always feel [s/he] can do things on [his/her] own and may find it silly that others think [s/he] needs the help ...I wonder if a different approach would work, such as just complimenting [his/her] hair or asking [him/her] a simple tip about long hair. Or something similar to [his/her] clothing - complimenting a shirt you see in [his/her] closet and letting [him/her] know how good I bet [s/he] looks in it."

- 07/12/2023: "Continues to be very anxious around receiving assistance for cares. Does not like feeling helpless and wants to be able to do things independently ...allow [him/her] to do as much as [s/he] is able and use verbal cues as needed. Then if physical assistance is required, offer this as a last resort ... Continue offering positive touch for [him/her], such as painting [his/her] nails, offering to do [his/her] hair, apply make-up, etc."

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{N 389}	Continued From page 33 - 09/14/2023: " ...staff report [s/he] continues to refuse all cares ...If [s/he] has a favorite caregiver, ask if that person would be able to be on stand-by assist initially for a few showers then gradually move to offering to help [him/her] reach the harder to reach areas... flushable wipes, perhaps encourage these after restroom use ... also to eventually help wipe down folds/hard to reach spots. Try to offer [him/her] spa/pamper days that are not care related so [s/he] gets used to others doing [his/her] hair or painting [his/her] nails ... start out small, such as just encouraging [him/her] to come out of [his/her] room for a little bit. When [s/he's] out, see if [s/he'd] let you pamper [him/her] a little or just talk with [him/her] to create those human connections that [s/he] doesn't associate with tasks [s/he] doesn't like ... The goal is to not have [him/her] associate all staff with cares or tasks but rather see a staff person and immediately feel as ease." - 10/30/2023: "Continues to refuse cares and assistance with the restroom ... Continue offering 1:1 social visits to paint nails and talk with [him/her] to encourage better rapport/trust with staff to hopefully lead to [him/her] accepting some assistance with cares ... offer bath wipes to assist with hygiene." On 11/13/2023, Resident 7's physician ordered lorazepam 0.5mg PRN. Resident 7's physician wrote to staff on 11/13/2023 on the Bridge communication portal: "The medication would be administered in anticipation of preforming cares. Staff, See order for agitation and to help with facilitating cares - give prn 45 minutes prior to planned care."	{N 389}		

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{N 389}	Continued From page 34 Surveyor reviewed Resident 7's ISP, updated 01/07/2024. Page 1 read, "Staff will monitor the safety of resident/tenant related to medical diagnoses." The diagnoses listed on the ISP were as follows: - Unspecified atrial fibrillation - Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety - Hypertensive heart disease without heart failure - Congestive heart failure - Type 2 diabetes without complications - Dorsalgia, unspecified - Encephalopathy, unspecified Resident 7's ISP did not reference his/her major depressive disorder with psychotic symptoms, recurrent UTIs (urinary tract infections), kidney disease, COPD, chronic pain, or GERD. Resident 7's ISP read, "EATING/MEALS: ... staff to encourage eating [sic] resident will often refuse. 12/29/2023 ... Resident needs preparation of all meals. Date Initiated: 05/04/2023." The ISP did not reference Resident 7's need for dietary supplements (Ensure). According to Resident 7's medication administration records (MAR) for August 2023 through January 2024, Resident 7's Ensure was administered to Resident 7 for the first time on 12/27/2023. Resident 7's ISP referenced Resident 7's tendency to refuse staff assistance: - "TOILETING ... Staff to assist with toileting every 2 hours as resident allows. Resident will often refuse to allow staff to assist [him/her] and will attempt to change [her/himself]." -"Staff to assist resident with bladder function to ensure cleanliness. Resident will often refuse	{N 389}		

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assistance with toileting and attempt to toilet [her/himself]."
- "Staff to assist resident with bowel function to ensure cleanliness. Resident will often refuse assistance with toileting and attempt to toilet [her/himself]."
- "BATHING ... Resident requires assist of one staff throughout the entire shower and staff will need to highly encourage bathing on scheduled shower days. If resident refuses cares family has request [sic] to be notified when [s/he] refuses to shower. 08/14/23"
- "GROOMING/ORAL HYGIENE ... will be able to maintain appropriate grooming and hygiene with assistance but often will refuse staff assistance."
- "RESISTIVE TO CARE: Resident will often refuse cares ... Will accept the assistance or [sic] empathetic caregivers who are sensitive to his/her care needs, know preferences, routines, give choices, and encourage independence. Date Initiated: 08/22/2023 ... Give clear explanation of all care activities prior to and as they occur during each contact ... Date Initiated: 08/22/2023. Revision on: 08/29/2023."

The ISP did not include reference to Resident 7's PRN psychotropic medication ordered on 11/13/2023 to assist with care compliance. The ISP also did not include approaches suggested by Resident 7's behavioral health clinician such as offering social visits, unscheduled pampering, rephrasing verbal cues to encourage independence/self-determination, offering wipes, etc.

On 02/15/2025, at approximately 10:00 AM, Surveyor interviewed Administrator A and QA/FHM B. QA/FHM B stated staff were responsible for monitoring for any changes related to Resident 7's diagnoses list.

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{N 389}	Continued From page 36 Administrator A stated s/he entered Resident 7's diagnoses on his/her ISP. Surveyor asked if there was a reason Resident 7's diagnoses related to major depression with psychotic symptoms, recurrent UTIs, kidney disease, COPD, chronic pain, or GERD were not on his/her ISP; Administrator A shook his/her head no. Surveyor inquired about Resident 7's dietary supplement ordered in August and again in December. QA/FHM B stated dietary supplements, such as Ensure, should be on the ISP under the nutrition section. Surveyor asked about Resident 7's interventions related to refusal of care. QA/FHM B stated the ISP should have included Resident 7's interventions and approaches. Administrator A stated s/he was aware of the requirement to include psychotropic PRN parameters on ISPs. Cross Reference N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0433 DHS 83.38(1)(i) Behavior Management	{N 389}		
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	N 431		

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N 431	Continued From page 37 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 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 record review and interview, the provider did not ensure health monitoring systems. The provider did not monitor Resident 7's weight weekly as prescribed and did not timely report significant changes in Resident 7's weight or deviations from Resident 7's prescribed diet, to Resident 7's physician. Resident 7 lost 120 lbs. during his/her 8-month placement at the facility. The provider did not monitor Resident 14's oxygen levels or maintain communication with Resident 14's physician to report significant changes in oxygen status.	N 431		

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N 431	Continued From page 38 This is a repeat violation. See Statement of Deficiency (SOD) 92G311, dated 9/1/2021. Findings include: The Department received 3 complaints in January and February 2024 with concerns related to the provider's health services. RESIDENT 7 On 01/11/2024, the Department received an investigation report from Sergeant P of the St. Croix County police department. The report indicated the police department received a call on 01/03/2024 about a resident that appeared to have been neglected and was being transferred to a second hospital for an emergency procedure. Sergeant P went to the hospital and met with Resident 7 and his/her family. The report read, in part: "[Family Member (FM) Q] stated that over the past few months ... [Resident 7] appeared to have lost weight ... [FM Q] stated that [s/he] ...purchased a couple cases of Ensure for [Resident 7] and placed them in [his/her] room. [FM Q] also requested that [Resident 7's physician] ... put in an order to [provider] would [sic] provide the shakes to [Resident 7]. [FM Q] explained that [Resident 7's physician] did order that for [Resident 7], and while [s/he] or [FM Q's spouse] would visit [Resident 7] they would give shakes to [Resident 7]. [FM Q] stated that when they gave the Ensure to [Resident 7] that [s/he] would consume two or three and appeared ravenously hungry. They asked [him/her] if [s/he] was hungry and [Resident 7] would tell them [s/he] was ... [FM Q] asked staff if [Resident 7] was eating they would often tell [FM Q] that [Resident 7] did not eat	N 431		

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because [s/he] refused. [FM Q] asked them how often they were weighing [Resident 7] [s/he] was told weekly ... On 12-26-2023 [FM Q] brought [his/her] own scale with [him/her] and asked staff if they would weigh [Resident 7] ... At that time [Resident 7] was 143 lbs ...

On 01-03-2024 [FM Q] demanded an emergency visit from [Resident 7's physician] because [Resident 7] was so weak and had not been [his/her] baseline for several weeks. [Resident 7's physician] told [FM Q] that they could either start making arrangement [sic] to place [Resident 7] on hospice care or [s/he] would need to go to the hospital because [s/he] did not have time to see [Resident 7] ... [FM Q] asked that [provider] staff call for an ambulance, and they did."

On 01/30/2024 at approximately 2:25 PM, Regional Director (RD) C explained that the provider utilized a rounding physician service and all communication between the provider and the medical provider was captured in the online portal referred to as The Bridge.
Between 01/30/2024 and 02/01/2024, Surveyor reviewed Resident 7's records. Records were obtained from the provider directly on 01/30/2024 and 01/31/2023, the St. Croix police department on 01/31/2024, and the provider's electronic charting system on 02/01/2024.

Resident 7 was admitted to the facility on 05/04/2023 and discharged to the hospital on 01/07/2024.

The following information was obtained by the provider prior to admission:
1) A comprehensive medical assessment completed on 02/14/2023. The assessment indicated Resident 7 had an extensive list of

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medical and mental health diagnoses that included the following:
- Major depressive disorder, severe, recurrent, with psychotic symptoms
- Dementia, unspecified with mood disturbance
- Chronic diastolic (congestive) heart failure.
"Plan: Continue weekly wts. [weights] ... Monitor for heart failure symptoms (wt gain/edema/SOB)."
- Morbid obesity with comorbid diabetes, hyperlipidemia, and heart failure. "Plan: ... Continue to monitor wt weekly."

2) A medical appointment summary, dated 04/05/2023, which read:
"Staff report new hallucinations, confusion, chills, weakness, severe worsening incontinence ... Very poor hygiene recently and refusing staff assistance: strong odor in room ... History of recurrent infections with rapid health decline and secondary falls ... Increased edema noted in LEs [lower extremities] but no redness/warmth. Legs were lightly tender to touch today ...
Plan: ... UA (urinary analysis) pending: started cefdinir 300mg BID (twice a day) x 7 days due to significant clinical symptoms and history of UTIs (urinary tract infections) with similar presentation and rapid decline ... Monitor skin integrity of LE's hx [history] of cellulitis 2022 ... Continue weekly wts."

4/25/23 Addendum:
Received noticed that [Resident 7] will be moving to [provider] in Hudson by the end of next week ... Ongoing mouth pain- Needs teeth extracted."

3) Admission treatment orders signed by Resident 7's physician 04/25/2023, that read:
"Weigh weekly before breakfast."

According to Resident 7's physician

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communication notes (The Bridge), Resident 7 had significant mouth pain related to infected teeth, resulting in multiple extractions. The pain caused Resident 7 to refuse meals. His/her physician ordered a mechanical soft diet on 08/07/2023. On 08/21/2023, Administrator A wrote, "Looking at [Resident 7's] weight records between June and now [s/he] lost 26 pounds." Resident 7's physician ordered Ensure dietary supplement BID with meals on 08/22/2023. Administrator A confirmed receipt of the order on The Bridge on 08/22/2023.

Resident 7's family continued to raise concern that Resident 7 was not getting his/her prescribed dietary supplement and not getting proper nutrition:
- 9/8/23, FM N - "We called the nurse and were told the staff was unaware that [Resident 7] was supposed to be getting Ensure... [Resident 7] has more extractions scheduled for next week so [s/he] likely will continue to need these dietary supplements."
- 9/11/23, FM N - "can you confirm if [Resident 7] is getting Ensure protein drinks daily? We need to make sure the facility is handling this at least until [his/her] dental work is complete (probably several more weeks) - because with [his/her] teeth and extraction surgery's, [s/he] is not able to eat anything solid."
- 9/14/23, FM N - "What we know: [S/he] is not eating ... If [s/he] says [s/he] is, that is simply not the case. [S/he] needs to be told by [Provider] staff to eat... [His/her] teeth extraction process is still ongoing. [S/he] only can eat certain foods and ensure protein drinks seem to sit well with [him/her]. Please make sure the [Provider] staff is providing these in supplement to [his/her] meals so [s/he] is at least getting minimal nutrients per day."

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N 431	Continued From page 42 - 9/14/23, FM O - "As we are quite certain [s/he] is not eating ... Can we make sure [s/he] gets 4 or more ensure [sic] drinks a day? - 10/30/23, FM N - "Are we sure that [s/he] is eating properly? It seems when [s/he] does not eat [s/he] gets very confused. [S/he] just had all her teeth pulled and is a waiting [sic] period for denture placement - so [s/he] cannot eat anything solid. You mention that [s/he] is getting Ensures. Is that what [Resident 7] says or what staff is saying - do you know how often staff is giving them to [him/her]? I have yet to see the Ensures being brought to [him/her]?" On 12/26/23, Administrator A wrote on The Bridge, "[Resident 7] has had a weight decrease over the past few months. October [s/he] was 216, Nov 172 and today weight [s/he] is 143.1." The following responses followed Administrator A's notification: - FM N wrote, "[Administrator A]:.. Thank you for taking time this morning to discuss family concerns about [Resident 7's] weight loss and for requesting the staff get a current weight today. You indicated [his/her] weight was 210-216 in early December (and you estimated [his/her] weight was taken some time between Dec 1-5). Today's weight was 141.7. Even if the staff had taken December's weight with [his/her] walker as you suggested, the walker weighs 28lbs so that is still a very significant weight loss in 20-25 days. (Approximately 40-47 pounds). The family has observed [him/her] being so out of it, [s/he] doesn't even seem to notice [s/he] is hungry but when handed a protein shake, [s/he] guzzles it. We watched [him/her] struggle to eat a couple pieces of watermelon the other day so I am not even sure [s/he] is currently capable of swallowing anything but a liquid diet. [S/he] was so weak today, [s/he] struggles to even stand and	N 431		

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N 431	Continued From page 43 as you know, it resulted in a fall today ... since [Provider] has not been able to supply [him/her] with protein shakes, starting today, [his/her] refrigerator will be stocked with protein shakes the family will provide. I am asking for [Resident 7's physician] to please put in an order that [s/he] is to be given a shake (or ½ - whatever [s/he] thinks is appropriate) 2-3 times a day so it can be administered in a systematic format just like any life saving [sic] medication would be." - Resident 7's physician replied, "Has she been getting a dietary supplement regularly?" - FM N responded, "No [Administrator A] confirmed this morning that [Resident 7] has not been getting any supplements. There is a discrepancy over who should supply/pay for it. We will pay for the supplements but we need help getting them administered to [him/her] on a consistent basis. I just noticed [Administrator A's] message about [Resident 7's] weight tracking and that is not what was communicated to me this morning. I was told Nov and Dec weights were consistent around 210-216 and that weight is always taken in the beginning of the month so [Administrator A] estimates [Resident 7's] December weight was taken some time between Dec 1-5." On 12/27/2023, Resident 7's physician sent in a new order for Ensure 3 times a day with meals. Administrator A confirmed receipt of the order on The Bridge on 12/27/2023: "Thanks for the order [sic] it will be added to her medication list." Surveyor reviewed Resident 7's medication administration records (MAR) for May 2023 through January 2024. According to this record, Resident 7 was administered Ensure dietary supplement for the first time on 12/27/2023, with his/her evening meal.	N 431		

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N 431	Continued From page 44 Resident 7's MARs also included a scheduled treatment that read, "Check weight before breakfast once a week in the morning for Fluid [sic] increase." Staff charted that the treatment was "administered" almost daily throughout Resident 7's placement, and they input a weight each time the treatment was administered. The weights recorded on the MAR were the same (to the tenth of a pound) for extended days in a row, and when the weight did change on the MAR, it correlated to a new weight recorded in Resident 7's vital record. The following is a list of Resident 7's weights obtained by the provider (all weights were obtained from the vital log unless otherwise specified): - 05/05/2023 - 261 lbs. - 05/08/2023 - 261 lbs. -05/22/2023 - 262 lbs. - 05/29/2023 - 263 lbs. - 06/01/2023 - 262.4 lbs. - 06/03/2023 - 264 lbs. - 06/05/2023- 262 lbs. - 07/07/2023 - 235.2 lbs. - 07/29/2023 - 234 lbs. - 08/03/2023 - 208.9 lbs. - 08/07/2023 - 214 lbs. - 08/09/2023 - 224.4 lbs. - 08/13/2023 - 208 lbs. - 08/14/2023 - 209.4 lbs. - 08/17/2023 - 208.9 lbs. (Rounding physician form) - 08/22/2023 - 205.8 lbs. - 09/05/2023 - 217.2 lbs. - 10/23/2023 - 216 lbs. - 10/25/2023 - 216.2 lbs. - 11/05/2023 - 218.4 lbs.	N 431		

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N 431	Continued From page 45 - 11/15/2023 - 172.4 lbs. - 12/04/2023 - 215.2 lbs. (monthly nurse assessment) - 12/26/2023 - 143.1 lbs. Based on Surveyor's knowledge of the provider's systems from past surveys and the rounding physician forms provided during the current survey, the provider's rounding physician obtained his/her weights from the provider. Facility staff completed the top portion of the rounding physician form prior to each appointment; this top portion included the provider's vital information (including last obtained weight) and a list of any health concerns the provider wanted the physician to address. Resident 7's record included 7 rounding physician forms; the weights on each of the rounding physician forms matched the last obtained weight on the provider's vital record. This system potentially caused Resident 7's physician to not have the most accurate information for Resident 7 at each appointment. For instance, Resident 7's rounding physician form, dated 11/13/2023, indicated Resident 7's weight was 218.4 lbs., which was the weight obtained by the provider 8 days prior on 11/05/2023. The vital log indicated Resident 7 was weighed on 11/15/2023 (2 days after the physician appointment) and was found to be 172.4 lbs. Based on The Bridge, the provider did not notify Resident 7's physician of a significant weight decrease until 12/26/2023. Assistant Manager (AM) L wrote on The Bridge on 01/03/2024 that Resident 7 was sent to the ER (emergency room) per family request. On 01/04/2024, Resident 7's physician added the following update on Resident 7's status: "Received a call from [hospital nurse] ... [s/he]	N 431		

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N 431	Continued From page 46 had some questions about weight loss over the last couple months. Passed along documented weights on file- discussed past hospitalizations ... and reviewed attempted diet modifications and initiation of dietary supplements in attempt to stabilize weight. Hospital has recorded weight of 144 lbs. [Resident 7] remains inpatient at Hudson- found to have hydronephrosis of left kidney s/p stenting, no stone found. Treating for possible UTI, UC pending. Plan for speech and dietician consult." On 02/15/2024 at 10:00 AM, Surveyor interviewed Administrator A and Quality Assurance/Float House Manager (QA/FHM) B. Surveyor asked if staff were weighing Resident 7 each time they recorded Resident 7's weight in the MAR. Administrator A responded, "I would assume so." QA/FHM B reviewed the documents and stated, "Based on charting, it looks like they weighed [him/her] each time ... hard for us to know if they actually weighed [him/her] each time." QA/FHM B said managers were responsible for reviewing MARs for accuracy. QA/FHM B stated Resident 7's physician also reviewed Resident 7's MARs at each appointment. Surveyor voiced concern that staff were documenting they were monitoring Resident 7's weight more often than they were. QA/FHM B stated s/he understood the concern. Surveyor asked why Resident 7 had an order for weekly weights, and what staff were to monitor for. Administrator A responded, "I'm not positive." Administrator A guessed staff were supposed to monitor Resident 7 for weight loss. QA/FHM B stated the provider's policy was to notify physicians anytime a resident had a 6-pound change in their weight.	N 431		

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N 431	Continued From page 47 Surveyor asked Administrator A why Ensure was not added to Resident 7's MAR until 12/27/2023. Administrator A responded, "It was missed." The provider did not monitor Resident 7's weight weekly as prescribed and did not timely report significant changes in Resident 7's weight or deviations from Resident 7's prescribed diet to Resident 7's physician. Resident 7 lost 120 lbs. during his/her 8-month placement at the facility. RESIDENT 14 On 02/07/2024, Surveyor requested to review Resident 14's record, including, but not limited to, the individual service plan (ISP), health concerns/changes in condition documentation, staff charting notes, task administration record (TAR), medication administration record (MAR), and discharge information. Resident 14 had an admission date of 10/25/2022 and had the following medical conditions: chronic obstructive pulmonary disease with acute exacerbation, essential primary hypertension. Resident 14 was discharged from the facility on 11/03/2023. A document with the title, "DISCHARGE FORM," stated the reason for discharge was "needed more cares." Surveyor reviewed the physician orders received, as requested from QA/FHM B. There were two documents with the title "Physician Rounding Form," which read: -10/02/2023: Provider Orders/Communication to Nurse: Sent to ER (emergency room) for further eval (evaluation) & treatment- hypoxia with	N 431		

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increased O2 (oxygen) needs, somnolence (drowsiness), confusion.

-10/09/2023: Nursing communication to Provider-Hospital f/u (follow-up) enrolled with [hospice agency name] 10/05. Provider Orders/Communication to Nurse- No changes. Continue hospice care.

Surveyor reviewed the MAR for September 2023. The MAR had an order that read, "Check oxygen twice a day and alert if O2 sat (saturation) is <88% two times a day for oxygen." The MAR was complete with staff initials and checks for the entire month.

Surveyor reviewed the MAR for October 2023. The MAR had an order that read, "Check oxygen twice a day and alert if O2 sat is <88% two times a day for oxygen. The MAR showed staff documented checks occurred on 10/01/2023 and then coded resident was "hospitalized" or "absent from the home with or without meds," on 10/02/2023-10/06/2023, with an oxygen check completed at 8:00 PM on 10/06/2023.

The MAR did not indicate what Resident 14's oxygen level was at the time of each check and only documented staff initials with a check mark showing the oxygen check had been completed. On 01/30/2024, Surveyor requested medical records for multiple residents from Regional Director (RD) C. At approximately 2:25 PM, RD C explained that the provider utilized a rounding physician service and all communication between the provider and the medical provider was captured in the online portal referred to as The Bridge. RD C stated the provider lost access to The Bridge when a resident discharged from their facility but Surveyor could request the record from

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the medical provider. RD C stated the provider did not have a system to maintain this physician communication in their own records.

On 02/20/2024 at approximately 2:45 PM, Surveyor interviewed Manager of Clinical Services (MCS) O from the hospice agency, regarding Resident 14's admission to receive hospice services after s/he was hospitalized on 10/02/2024. MCS O confirmed Resident 14 was admitted to hospice and discharged from the facility on 11/03/2023 to a different facility. MCS O stated the goal upon admission to hospice was to find alternative placement in response to family concerns with his/her care at the facility. The family did not feel Resident 14 was receiving the best care.

Surveyor asked MCS O what prompted the admission to hospice services. MCS O reviewed the admission note and reported, "Resident 14 had many hospitalizations over the past year and a recent hospitalization within the last 7 days due to shortness of breath and weakness." MCS O further stated that Resident 14 was sent to the hospital on 10/02 with chronic hypoxic respiratory failure.

During the interview, MCS O reviewed the History and Physical (H&P) documentation from the hospital and stated the report read, "Resident's O2 had not been working properly so they were not sure how long s/he was not getting oxygen. Resident 14 was hypoxic in the emergency department, had poor air movement and wheezes, significantly elevated CO2 levels and required high flow oxygen treatment."

MCS O informed Surveyor the H&P indicated s/he was hypoxic on arrival and required high flow

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N 431	Continued From page 50 35L (liters) nasal cannula for air movement, wheezing in the ED, with a baseline of 3L of oxygen. MCS O stated high flow is usually 10L or greater, so it appeared Resident 14's respiratory failure was going on for a long time prior to presenting at the hospital on 10/02/2023. MCS O stated Resident 14 had returned to the facility with a Triology machine (ventilator type machine) and did not like the mask. There was some inconsistency with oxygen use so hospice had to send out regulators from the durable medical equipment (DME) company so s/he could use the upright tanks instead of the Triology machine. MCS O stated the hospice nurse attempted to provide staff with training on the machine to ensure staff competency but there were concerns from family regarding Resident 14's care prior to admission to hospice. On 02/20/2024, Surveyor requested hospital discharge paperwork and visit summary for Resident 14's hospitalization on 10/02/2023, from Administrator A and QA/FHM B. On 02/21/2024 at 11:04 AM, QA/FHM B replied via email and stated, "Attached are the transfer orders from [hospital name] that the facility received for [his/her] hospital visit on 10/02/23 ... [S/he] was evaluated in the ED (emergency department) on 07/10/2023, Hospitalized [sic] on 10/02/2023 and 10/12/2023. I attached the summaries to this email." Surveyor reviewed the transfer orders that did not contain any information of the care Resident 14 received during his/her hospitalization that was reviewed with MCS O on 02/20/2024.	N 431		

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N 431	Continued From page 51 The 10/02/2024 transfer orders showed discharge medication orders, diet orders, and the order for the Triology machine, hospice referral, and oxygen order for 5L (5 liters), 24 hours per day. The 10/12/2024 transfer orders showed discharge medication orders, tuberculosis orders, referral to a skilled nursing facility, and oxygen order for 4L (4 liters), 24 hours per day. On 02/21/2024 at 11:04 AM, Surveyor received an email from QA/FHM B that stated Resident 14 was no longer on the physician portal so they were unable to obtain evidence that the physician was notified of changes in condition prior to 10/02/2023, aside from an order they had printed for a UA/UC (urinary albumin to creatinine ratio) on 09/19/2023 after s/he was noted to have confusion. QA/FHM B also informed Surveyor that staff were checking Resident 14's O2 levels, and would notify management if his/her O2 levels were under 88% but did not have the recordings as they would have been recorded in the MAR. On 02/21/2024 at 11:36 AM, Surveyor received an email from QA/FHM B that read, "The transfer orders are all we have on file. Regarding both 10/02 and 10/12, the MAR was not updated to reflect the change in liters." Surveyor asked QA/FHM B who was responsible for reviewing transfer orders and hospital visit summaries when a resident returns to the facility. On 02/21/2024 at 11:48 AM, QA/FHM B replied, "The assistant manager and house manager are both responsible for reviewing discharge	N 431		

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N 431	Continued From page 52 summary/orders when a resident returns from the hospital. For transcribing medications orders in the MAR, management sends new orders to the pharmacy, and they input them into Point Click Care (computer program) for management to confirm." The provider did not monitor Resident 14's health related to oxygen levels when documentation of his/her oxygen level was not recorded in the MAR upon each check. Resident 14 presented to the hospital on 10/02/2023, requiring high flow oxygen treatment. The provider did not maintain physician communication in the record for changes to Resident 14's health when the provider did not have access to the portal after the resident discharged from the facility.	N 431		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure Caregiver F administered medications appropriate to resident needs during the morning medication pass on 01/30/2024.	N 432		

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N 432	Continued From page 53 Findings include: The American Academy of Ophthalmology website (https://www.aao.org/eye-health/treatments/how-to-put-in-eye-drops), retrieved on 02/09/2024 states, in part: "The timing and dosage of your eye drops can make a big difference in your treatment. Whether you're using drops for glaucoma, dry eye, an infection, or an allergy, you must use the drops correctly to get the full benefit. If you ' re having trouble getting the drops in or using them on the right schedule, talk to your ophthalmologist about your options. -Use your drops exactly when and how your doctor tells you to. -If you need to take more than one type of eye drop at the same time, wait 3 to 5 minutes between the different kinds of medication. -Always wash your hands before handling your eye drops or touching your eyes." On 01/30/2024 at 10:00 AM, Caregiver F entered Resident 1's room and administered 1 drop of Sodium Chloride 5% into both eyes. After administering the Sodium Chloride drops, Caregiver F checked Resident 1's blood pressure and administered Refresh Tears into both eyes; approximately 45 seconds after the Sodium Chloride drops. Caregiver F returned to the medication cart outside Resident 1's room in the hallway, grabbed the medication keys and unlocked the cart. Caregiver F informed Surveyor Resident 1 had one more eye drop scheduled at 8:00 AM. Caregiver F retrieved the bottle of Prednisolone	N 432		

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N 432	Continued From page 54 eye drops from the medication cart. Surveyor asked Caregiver F if s/he administered the Sodium Chloride and Refresh Tears into both eyes. Caregiver F stated, "Yes, I did." Caregiver F read the label on the drops and informed Surveyor s/he did not read the labels. Caregiver F stated, "I'll be sure to only put this one (Prednisolone) in the left eye." Caregiver F closed the drawer, locked it, and entered Resident 1's room. On 01/30/2024 at 10:03 AM, Caregiver F entered Resident 1's room and administered 1 drop into the left eye and administered Resident 1's inhaler. Caregiver F stated, "I don't normally work this shift (morning), I work PMs (evenings) and I got called back in this morning because someone called in. Caregiver F further stated, "I worked last night and stayed up way too late and I'm running on 2 hours of sleep. I would be going faster but I don't do morning meds (medications) & have to look up who gets blood pressures and stuff. I'm supposed to be done by 9:00 (AM) but I'm getting them done. I didn't get here until about 7:30 (AM) to start. I know I'm behind schedule." Caregiver F administered 3 different eye drops within 3 minutes and did not complete hand hygiene prior to, or in between, administering the eye drops after touching multiple surfaces. On 01/30/2024 at 10:06 AM, Surveyor interviewed Caregiver F and asked if eye drops could be administered consecutively. Caregiver F stated s/he did not think about it and "probably should have waited." On 02/15/2024 at approximately 12:00 PM, Surveyor discussed the above concern with Administrator A. Administrator A stated staff	N 432		

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N 432	Continued From page 55 should wait 5 minutes between drops if multiple drops are given. Cross Reference N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0441 DHS 83.39(3) Hand Washing	N 432		
N 433	83.38(1)(i) Behavior management. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide or arrange for services to manage resident behaviors that may be harmful to themselves or others. Resident 4 was admitted with a history of harmful behaviors. The provider did not reassess Resident 4 or implement services to manage the behaviors as they appeared. Resident 9 was admitted with behaviors that included wandering and aggression/agitation. Behavior management services were not implemented during his/her placement and s/he was discharged due to his/her behaviors within 1 week of admission.	N 433		

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N 433	Continued From page 56 Findings include: This provider is licensed to serve up to 40 residents in the client groups: physically disabled, advanced aged, and irreversible dementia/Alzheimer's disease. In January 2024, the Department received complaints related to resident care and treatment. The complaints were substantiated. RESIDENT 4 On 01/30/2024, Surveyor requested to review Resident 4's record. Resident 4 had an admission date of 11/07/2023. The face sheet showed Resident 4 had the following diagnoses related to behavior: bipolar disorder, poisoning by methamphetamines, other long term (current) drug therapy, panic disorder. On 01/30/2024, the provider stated the dates of the progress note reflected below was the date approved by management, and not necessarily the date it was written. The provider informed Surveyors it was their policy for staff to write the date at the end of their entry note, but was not always completed. On 01/30/2024, Surveyor reviewed staff charting notes for Resident 4 that contained the following entries which read, in part: 2/1/2024 15:56: When staff entered room, resident continued to write a note on a napkin with a sharpie [sic], and the note stated "i [sic] am not crazy" [sic] when staff was noticed by resident [s/he] put the cap back on the marker and did not continue. 1/29/24 [initials] Noted [initials] 2/1/24	N 433		

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N 433	Continued From page 57 2/1/2024 15:51: resident [sic] asked staff to come to their [sic] room and talk in private, then proceeded to lock the door and close the blinds... Resident continued to talk about baby ducklings in [his/her] room, needing to eat [sic] resident proceeded to stomp on goldfish all over the floor. 1/29/24 [initials]. Noted [initials] 2/1/24 2/1/2024 15:51: resident [sic] took a sip of chocolate milk and spit it back into the cup Because [sic] resident was complaining of mouth being sore due to growing [his/her] third set of teeth and explained it ran in the family. 1/29/24 [initials] Noted [sic] [initials] 2/1/24 2/1/2024 15:50: Resident is trying to wake everybody up and getting upset saying "it's time to go to college" [sic] staff tried to redirect [him/her] multiple times. -[initials] Noted [initials] 2/1/24 2/1/2024 15:50: resident [sic] asked to be taken to their [sic] room by staff due to locking themselves [sic] out on walk to the room. Resident knocked on all the doors along the way, and threatened to stab staff with [his/her] water bottle, if threatened to be taken away from [him/her]. 1/29/24 [initials]. Noted [initials] 2/1/24 2/1/2024 15:49: Resident went to room #4 trying to wake [him/her] up stating "that's my friend and were [sic] going out together". -[initials] Noted [initials] 2/1/24 2/1/2024 15:46: Around 4:40 resident pull [sic] the fire alarm and left the building [sic] staff try [sic] to stop [him/her] but was no [sic] possible, [sic] staff called the Police to make the report. Management notified. At 5:10 resident was found	N 433		

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N 433	Continued From page 58	N 433		

by the police and brought back. The fire chief was here to fix the alarm. [initials] Noted [initials] 2/1/24

2/1/2024 15:46: At 5:45am resident pull [sic] the fire alarm again and left the building. The police had to be called again. The fire department was here as well. They want management to take care of this. Management notified. [initials] Noted [initials] 2/1/24

[Resident 4] took the bottle and poured it in [another resident's] cup and told [him/her] [s/he] had to drink it because it would clean [his/her] system and make [him/her] smarter convincing [other resident] to drink [sic] Noted [initials] 2/1/24

2/1/2024 15:44: Continue... [Resident 4] refused to give back the Q3 (sanitizer) bottle, [s/he] told [Resident 3] that [s/he] would give it to [him/her] later. Police arrived at the building and couldn't take [him/her] because they didn't have enough reason take [him/her] in and [s/he] already has depression and anxiety problems since [s/he] was admitted here. Noted [initials] 2/1/24

2/1/2024 15:41: Resident has stated [s/he] will not take anymore [sic] meds from staff because [s/he] doesn't want to be poisoned when [s/he] reincarnates into a grizzly bear. Resident also pulled emergency light and when staff entered the room they we silenced because [his/her] baby was asleep in the bathroom. [initials] 11:30 1/27/24 Noted [initials] 2/1/24

2/1/2024 15:41: Residents mood has been changing all day where [s/he] has either been wandering the building entering rooms that aren't [his/hers] and taking things or laying [sic] in bed

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N 433	Continued From page 59 where [s/he] yells/threatens staff about random hysteric scenarios. [initials] 1/27/24 11:30 pm Noted [initials] 2/1/24 2/1/2024 15:40: Resident refused all 8 pm meds. [S/he] took them all at once in [his/her] mouth, took a big sip of water, and then proceeded to turn and spit all contents at staff. Pills were picked up and disposed of properly. [S/he] then threatened staff to get out before [s/he] needs to "do something else". [initials] 11:30 1/27/24 Noted [initials] 2/1/24 1/29/2024 10:50: Resident has had behaviors that are not normal for the past 5-6 days. Resident has threatened to stab staff with sharp objects. The resident has pulled the fire alarm multiple times and pushed [his/her] way through the door to get out of the facility, Staff hadto [sic] go after [him/her] and she swung to hit staff. Resident is talking about things that are not really here. [S/he] is stating that [s/he] wants to die and [s/he] wants to be with [his/her] soulmate that has died. Staff had called 911 to try and get [him/her] some help and they refused to take [him/her] in. As soon as the police left [his/her] behavior's [sic] started again. The resident is really struggling with [his/her] mental health and has been a danger to [him/herself] and others. 1/28/2024 11:06: On 01/27 resident was experiencing suicidal behaviors and was a threat to [him/herself] and other resident [sic]. police [sic] and EMT were contacted and refused to take [him/her] into the Emergency Department to be evaluated. Resident is still residing at [Provider]. [managed care organization (MCO name] informed about resident behaviors and refusal of transport to ED and stated they would follow up on Tuesday 01/30/24. [initials]	N 433		

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N 433	Continued From page 60 1/28/2024 11:05: On 01/28/24 resident pulled the fire alarm and tried eloping. Staff were able to redirect [him/her] back into the facility. 1/25/2024 16:11: Resident pulled call light at 7:00 am. Very emotional and crying. States [s/he] cant [sic] stay warm and need [sic] something warm to help the pain. Staff offered warm blankets. Noted-[initials] 1/25/2024 16:08: Resident requested anxiety medication at 8:10am and it was ineffective. [S/he] has been having lots of behaviors and may have a uti (urinary tract infection) [sic] [s/he] is newly Experiencing [sic] incontinency. [initials] 1/24 UA/UC (urinary albumin to creatinine ratio) requesting awaiting on sample .01/25- [initials] 1/12/2024 09:43: Resident requested a PRN (as needed) anxiety pill and [s/he] said [s/he] wont [sic] take it because its [sic] not the right one. [S/he]s [sic] yelling at staff that [s/he] will call 911 because [s/he]s [sic] not being threaten [sic] like a human being. [initials] Noted-[initials] 1/10/2024 10:32: Resident requested prn (as needed) quetiapine 50mg at 7:53am and it was ineffective. [S/he] has been crying a lot today and having lots of anxiety. [initials] 1/7 Noted [initials] 1/10 1/3/2024 17:40: Resident requested anxiety medication this morning at 7:30am and it was unknown if it was effective [s/he] still is making suicidal comments. [initials] 1/3/24 Noted [initials] 1/3 1/3/2024 17:27: Resident has been calling for her anxiety PRN but when staff brings her the PRN to	N 433		

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N 433	Continued From page 61 [him/her] [sic] [s/he] refuses it stating that someone wants to poison [him/her]. [initials] NOted [sic] [initials] 1/3 12/18/2023 18:34: Resident requested prn for anxiety, stating [s/he] was anxious and wanted to commit suicide, [sic] staff gave prn for anxiety at 8:29am and will check effectiveness. [initials] 12/17/23 12/12/2023 20:09: Resident did not come out of [his/her] room at all today [sic] [s/he] seems very depressed. Management notified. [initials] 12/7 12/12/2023 19:56: Resident has been stealing from [room #] and any open door, and has seemed more confused than usual. Resident has taken multiple rolls off med cart of trash bags and opened them all over [his/her] room, then being confused about all of [his/her] missing items when nothing is missing. 12/12/2023 19:50: Resident has been very Paranoid today [sic] [s/he] told staff that [s/he]'s dead and walking in [his/her] spiritual [sic] and this lasted all day. [S/he] was saying the cops were out to get [him/her] all day and has been packing up [his/her] room. interventions [sic] are helpful but only for a little bit. [S/he] is more confused may have a uti [sic]. 12/12/2023 19:47: Resident requested prn hydroxyzine today and it was not effective. [S/he] keeps saying [s/he] is going to die and needs to confess to the cops. Is non stop [sic] anxious and staff are having a hard time figuring out where [his/her] anxiety is coming from because [his/her] speechseems [sic] off. Manegement [sic] updated. 12/10	N 433		

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N 433	Continued From page 62 12/12/2023 19:46: At 4:10am resident called the police and told them that [s/he] got shot once and the [sic] [s/he] was not safe here and a lot [sic] of other things. The Police were worried about [his/her] safety. 12/12/2023 19:45: Resident is looking for the phones to call the police because [s/he] needs then [sic] to find [his/her] dead mother, [s/he] stated that [his/her] mother died 21 years ago, [s/he]s [sic] been pulling [his/her] calling [sic] cord multiple times [sic] [s/he] did not sleep at all the whole night. 12/4/2023 13:19: Resident was yelling at staff because [s/he] wanted a blanket for another resident and when staff told [him/her] that they would assist [him/her] in a minute [s/he] got so upset and was being so rude to staff. 11/30/2023 07:31: Resident is very depressed and is talking about suicide. Surveyor requested Resident 4's temporary service plan (TSP) and comprehensive 30-day individual service plan (ISP) from Quality Assurance/Float House Manager (QA/FHM) B. On 02/01/2024 at 2:41 PM, Surveyor received an email from QA/FHM B that read, "Attached is [Resident 4]'s Temporary Service Plan and H&P from prior to admission. The facility was communicating with [social worker] at the Senior Living [sic] [s/he] was previously residing at. We do not have a signed Service Plan; however, I did attach [his/her] current Service Plan." On 02/01/2024, Surveyor reviewed the TSP received from QA/FHM B. The TSP did not address or identify any behaviors.	N 433		

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N 433	Continued From page 63 Surveyor reviewed the ISP provided by QA/FHM B. The ISP did not address behaviors or crisis support utilized for Resident 4 when s/he experienced episodes requiring police and EMS to be notified with request for assistance. The ISP did not direct staff to what behaviors specifically Resident 4 exhibited and did not identify interventions or approaches for staff to utilize to assist in managing Resident 4's behaviors related to his/her bipolar disorder, anxiety, paranoia, suicidal ideations, harm to others and exit seeking/wandering tendencies. RESIDENT 9: On 12/29/2023, the Department received a self-report from the provider indicating Resident 9 had a fall with injury on 12/16/2023, that resulted in an emergency room visit on 12/22/2023. The self-report read, "Resident will not be returning back to the facility due to mental health/behavioral concerns." On 01/03/2024, the Department received a notification from St. Croix County that included a copy of Resident 9's facility discharge form. The discharge form was signed by Assistant Manager (AM) L on 12/22/2023 and indicated Resident 9's reason for discharge was "mental health stay." The discharge form identified Social Worker (SW) M as Resident 9's "State Guardian." On 01/10/2024 at 8:22 AM, Surveyor interviewed SW M. SW M stated s/he was not Resident 9's guardian. SW M stated s/he was a behavioral health social worker who was involved due to Resident 9's protective placement order which placed Resident 9 at the facility on 12/15/2023. SW M stated Resident 9 was residing at home prior to placement at the facility but due to	N 433		

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ongoing concerns for [his/her] safety, s/he was hospitalized, and county protective services got involved. SW M stated Resident 9's guardian/child (Guardian R) requested Resident 9 be placed with the provider. SW M explained the provider had 2 facilities in Hudson - a secure memory care unit and a second facility. SW M stated the hospital staff and SW M requested Resident 9 be placed at the provider's secure memory care facility. SW M stated Regional Director (RD) C conducted the pre-admission assessment with Resident 9 at the hospital, and RD C determined Resident 9 was not appropriate for the provider's secure memory care facility, so Resident 9 was placed at the provider's second facility on 12/15/2023.

SW M stated s/he received a call from Administrator A on 12/20/2023. SW M asked about Resident 9 and Administrator A informed SW M that Resident 9 continued to elope and that s/he fell during one of the elopements. SW M stated, "I asked if [Resident 9] could go to [memory care unit] and [Administrator A] said no."

SW M stated s/he visited Resident 9 on 12/21/2023, assuming the fall occurred on 12/20/2023. SW M said Resident 9's wrist was obviously injured.

SW M said s/he received a call from a crisis responder around 7:00 PM on 12/21/2023 because Resident 9 was having a rough time.

On 12/22/2023, SW M called Administrator A to get an update on Resident 9 and the plan for his/her injured hand. SW M stated, "[Administrator A] said if [Resident 9] left the grounds [s/he] would be discharged. I said, 'What?!' [Administrator A] also told me if we

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wanted [Resident 9] to return to the facility, [s/he] would have to be re-referred and that [s/he] wouldn't likely not be accepted back...I reiterated over and over, 'So you're telling me [s/he] will be discharged?' [Administrator A] kept confirming that was correct."

On 01/30/2024 and 01/31/2024, Surveyor reviewed Resident 9's record. Resident 9 was admitted to the facility on 12/15/2023 and discharged 12/22/2023 due to mental health concerns and behaviors.

A petition for protective placement, filed on 12/13/2023 read, "Based on the Examining Physician's Report ...diagnoses with degenterative [sic] brain disorder, serious and persistent mental illness, and other like incapacities. It was reported on 12/12/23, that [Resident 9] entered [spouse's] room and began striking [him/her]. [Spouse] reported concern for [his/her] and [Resident 9's] safety. [Spouse] further reported that [Resident 9] had not eaten in the last two days and that [s/he] was unable to care for or meet [Resident 9's] needs ... The petitioner requested protective placement of the individual in the following facility: ... able to provide memory care."

Hospital records, dated 12/12/2023, read, " ...past medical history of ...alcohol abuse, PTSD, memory decline, presenting complaining of physical abuse. Law enforcement presents with the patient and states that they are reaching out to northwest connections to pursue chapter 5153 [sic]. Patient initially states that [spouse] was trying to touch [him/her] and [s/he] knee'd [sic] [him/her]. Later states that [spouse] actually tried to strangle [Resident 9]. On chart review, in the past, patient has complained of assault and

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multiple times police believe that this is false and that it was more a function of [Resident 9's] dementia and PTSD [post-traumatic stress disorder]. Reports from [spouse] ... [Resident 9's] memory has declined and become more paranoid and that [s/he] often claims that [spouse] assaulted [him/her]. Last note from Neurology on 05/24 stating that [Guardian R] also believes that these accusations are falls [sic]. Reports of periods of heavy drinking per neurology note. Patient states that [s/he] drinks about 2 beers per day."

Hospital course notes referenced Resident 9's confusion, agitation, "strong desire to leave," and need for interventions such as 1:1, redirection, medication refusal, and emergency plan in case of elopement:

12/13/23: "Pt [patient] noted to be confused/agitated at times and expressing strong desire to leave, have been successful with re-orientation this am ...Pt (patient) has not been consistent with taking [his/her] medications over the last few months ...[S/he] doesn't understand why [s/he] is still here, wants to go home. Thinks [s/he] was brought in yesterday because [s/he] went outside w/o [without] a warm enough coat on. Very forgetful, repetitive, agitated/paranoid at times during conversation."

12/14/23: "Pt seen ambulating with 1:1 in the halls. Feels okay. Wants to leave when [s/he] can ...Assessment/Plan: Awaiting Action For Housing ...
From 12/12 ED report: ...if pt becomes elopement risk, staff is unable to provide adequate care d/t (due to) not enough staff, or pt's guardian tries to pick pt up staff is to call law enforcement (per [SW M]) ... Continue hs

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[bedtime] Seroquel, Ramelteon. PRN Zyprexa available for agitation. Pt noted to be confused/agitated at times and expressing strong desire to leave, have been successful with re-orientation some as well. Continue 1:1 as needed."

A pre-admission assessment completed by RD C and Administrator S on 12/14/2023 indicated Resident 9 had behaviors that included confusion, depression, agitation, and anxiety. The assessment did not include reference to the behavioral interventions in place during Resident 9's hospital stay.

Resident 9's temporary ISP directed staff to monitor and document "any and all" behaviors. The temporary ISP did not provide details of Resident 9's harmful behaviors or how to prevent, manage, or respond to said behaviors.

According to staff charting, Resident 9 displayed behaviors that included: repetitive movements, yelling/screaming, wandering, refusal of care, pushing, kicking/hitting, wandering, verbal aggression, threatening behavior, and grabbing during 10 of the 20 staff shifts s/he resided at the facility. Behaviors were primarily noted on 1st and 3rd shifts.

Progress notes include the following references to incidents:
12/18/2023: "[Resident 9] is still displaying consistent behaviors such as anxiety/agitation/elopement attempts that are difficult to redirect. [Resident 9] has been refusing medications as well. Guardian has been notified by [QA/FHM B] of behavioral concerns."

12/19/23: "On 12/19/23 [Guardian R] was

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contacted ...We brought to [his/her] attention that [Resident 9] tried eloping from the facility for the second time."

12/21/23: Resident 9 eloped and began screaming when staff tried to redirect and s/he attempted to hit staff. "Police showed up they refused to take [Resident 9] into the hospital for [his/her] mental health, they had some guy come from the county that deals with those situations. [S/he] told me they couldn't get [him/her] into another facility until the morning and that [s/he] would for sure have [Resident 9] in a more secured facility where [s/he] needed to be the following day."

Surveyor reviewed Resident 9's medication orders and medication administration record (MAR). Resident 9 was prescribed quetiapine 25 mg twice a day as-needed (PRN) for agitation on 12/14/2023. Staff utilized this medication 7 of the possible 14 times during Resident 9's placement Each time it was documented as effective.

Surveyor reviewed Hudson Hospital records, dated 12/22/2023. The emergency department (ED) physician wrote at 12:26 PM, " ...[Provider] called and patient had been in their assisted living side although on my assessment [s/he] should have been in their memory care facility if [s/he] was on a chapter 55 prior ... needing a one-to-one with [his/her] intermittent agitation although [s/he] is redirectable. I do not think this is different than [his/her] baseline as I had seen [him/her] when [s/he] was initially for [sic] chaptered."

On 02/15/2024, Surveyor interviewed Administrator A and QA/FHM B. Surveyor asked if there was a reason Resident 9 was placed at the

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N 433	Continued From page 69 facility instead of the provider's memory care unit. QA/FHM B stated, "I'm not sure ... At the assessment [s/he] was not cognitively appropriate for [memory care unit]. [S/he] was able to hold a conversation... After seeing [him/her] at the facility, [s/he] was not appropriate ... [memory care unit] would have been more appropriate." Administrator A stated s/he did not speak with SW M prior to admission. Surveyor asked about behavioral interventions. Administrator A stated staff should have referred to the temporary ISP for direction. QA/FHM B reviewed the temporary ISP and stated it did not include a behavior focus (i.e., no interventions). Surveyor asked if there were interventions that seemed to help. QA/FHM B stated staff reported Resident 9's PRN medication helped temporarily. QA/FHM B stated s/he was unsure why staff did not utilize it more often. QA/FHM B said Resident 9 tended not to have behaviors when s/he was receiving one-to-one attention; Resident 9 was calmer when s/he had one-to-one which was provided by Guardian R. Administrator A confirmed Resident 9 was discharged due to his/her behaviors. Cross References: N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called N0328 DHS 83.31(4)(c) Involuntary Discharge Notice Requirements N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 433		
N 439	83.39(1) Infection control program.	N 439		

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N 439	Continued From page 70 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. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not establish and implement an infection control program based on current standards of practice to prevent the transmission of communicable disease and infection. Resident 5 was diagnosed with influenza A on 01/26/2024 and there were no systems in place to prevent the spread of infection on 01/30/2024. As of 02/15/2024, the provider had 5 confirmed cases and 3 suspected cases. Findings include: OBSERVATIONS & INTERVIEWS: During an entrance meeting on 01/30/2024 at 9:15 AM, Surveyor asked Administrator A if there were any transmission-based precautions in the building. Administrator A stated Resident 5 was diagnosed with influenza A on Friday, 01/26/2024. Administrator A stated Resident 5 was under isolation precautions but was feeling better. At 9:30 AM, Surveyor observed Resident 5 in his/her room with the door open. Resident 5 was coughing. No personal protective equipment was observed outside or directly inside Resident 5's room. Surveyor did not observe signage outside Resident 5's room indicating the level of precaution needed when entering. Surveyor interviewed Housekeeper G who was cleaning	N 439		

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N 439	Continued From page 71 directly across the hall from Resident 5's room. Housekeeper G stated Resident 5 looked ill today but staff were told Resident 5 could leave his/her room as of yesterday (01/29/2024). At 9:39 AM, Surveyor observed a caregiver push Resident 5 to the coffee station in the main living area. Neither Resident 5 nor the caregiver wore a mask. At 9:51 AM, Surveyor observed Resident 10 approach Caregiver D in the hallway. Resident 10 stated s/he did not feel well. Caregiver D encouraged Resident 10 to lie down because "a lot of people are getting sick." Caregiver D said there was a "bug" going around the facility. At 9:55 AM, Surveyor interviewed Caregiver D. Surveyor asked what s/he meant about a "bug" going around. Caregiver D stated, "I think [Resident 5] had the flu." Surveyor asked if staff followed any precautions when working with Resident 5. Caregiver D stated s/he would tie his/her hair back, put on gloves, and wear a surgical mask when s/he went into Resident 5's room. Surveyor asked what other residents were feeling ill and Caregiver D named Resident 3. Caregiver D stated Resident 3 was "old and frail" so s/he guessed his/her health change could have been part of his/her normal decline. At 10:30 AM, Surveyor interviewed Administrator A and Assistant Manager (AM) L. AM L stated Resident 3 was not feeling well but "[s/he] is on hospice, so [s/he] gets like this sometimes." Surveyor asked about his/her symptoms and Administrator A stated Resident 3 had a fever and was weaker than normal. Administrator A stated Resident 3 was not tested for influenza because s/he was on hospice.	N 439		

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N 439	Continued From page 72 At 11:37 AM to 12:15 PM, Surveyor observed the lunch meal. Resident 5 propelled him/herself in his/her wheelchair around the dining room with a pile of used tissues on his/her lap. Surveyor observed Resident 5 coughing and blowing his/her nose and placing the used tissues on his/her lap. Resident 5 did not have a mask on, and Surveyor did not observe staff encourage or offer one. At approximately 11:45 AM, Surveyor observed Resident 5 stop next to Resident 11, smile, and hold Resident 11's hand. Resident 5 sat at a table with 2 other residents for the duration of the meal. At 11:38 AM, Surveyor interviewed Housekeeper G, who was in the hallway near Resident 3's room. Surveyor observed a garbage can outside of Resident 3's room with a red garbage bag. Surveyor asked Housekeeper G why there was a red garbage bag in the can outside of the room. Housekeeper G stated, "We think [Resident 3] has whatever is going around and [s/he]'s going down and might die from it. The red bag and garbage can means [s/he]'s got something bad." Housekeeper G further stated, "[Resident 3]'s neighbor, [Resident 5] tested positive for Influenza a few days ago, last Friday I think? I don't think [s/he] (Resident 5) should be out of [his/her] room. [S/He]'s coughing up a storm today, but was told by my co-workers [s/he] could be out and about. [S/he] has been out of [his/her] room all day and still not feeling well; you can just tell." Surveyor asked Housekeeper G if the provider was doing any active surveillance for symptoms of staff or other residents for Influenza. Housekeeper G stated, "I don't know. [Caregiver H] had a high fever yesterday while at work, [s/he]	N 439		

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worked [his/her] whole shift and was coughing. Another person, [Caregiver I] also is out with a fever. [S/he] works second shift. With all the stuff going around, I hope I stay good."

At 5:43 PM, Surveyor interviewed Administrator A and Quality Assurance/Float House Manager (QA/FHM) B. Administrator A stated s/he notified staff of Resident 5's influenza diagnosis on 01/27/2024, via progress note. Surveyor asked if any staff had reported symptoms. Administrator A stated Caregiver H called in sick today. Administrator A stated s/he did not ask about Caregiver H's symptoms. Administrator A and QA/FHM B stated they were not aware of a staff member working last night with a fever. Administrator A stated s/he had not reported the confirmed influenza A infection to local public health. Surveyor asked about precautions that were put in place when Resident 5 returned from the hospital with confirmed influenza. Administrator A replied, "The discharge paperwork didn't say to have precautions." Surveyor asked Administrator A if s/he was aware of the Centers of Disease Control and Prevention (CDC) guidelines for preventing the spread of influenza. Administrator A stated s/he was not.

RECORD REVIEW:
On 01/30/2024, Surveyor reviewed the provider's infection control policy, which read:
"It is the policy of [provider] to establish and follow an infection control program based on current standards of practice to prevent the development or transmission of communicable disease and infections...

SCREENING...
Residents with communicable disease shall be identified and CDC guidelines followed...

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N 439	Continued From page 74 CONFIRMED COMMUNICABLE DISEASE Any communicable diseases [sic] shall be reported to the local public health department following CDC guidelines." According to the CDC, "Droplet precautions should be implemented for patients with suspected or confirmed influenza for 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while a patient is in a healthcare facility. In some cases, facilities may choose to apply droplet precautions for longer periods based on clinical judgment, such as in the case of young children or severely immunocompromised patients, who may shed influenza virus for longer periods of time... Healthcare settings should establish mechanisms and policies by which HCP [health care personnel] are promptly alerted about increased influenza activity in the community or if an outbreak occurs within the facility and when collection of clinical specimens for viral culture may help to inform public health efforts. Close communication and collaboration with local and state health authorities is recommended." (Retrieved 01/30/2024, https://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm) According to the Department of Health Services, influenza A is a category II disease which requires notification to local public health within 72 hours of recognition of a case or suspected case. (Retrieved 01/30/2024, https://www.dhs.wisconsin.gov/disease/reporting.htm) On 01/30/2024, Surveyor reviewed Resident 5's record. An emergency department after-visit	N 439		

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summary printed on 01/26/2024 at 3:40 PM, indicated Resident 5 was diagnosed with influenza A. Resident 5's physician portal indicated Resident 5 returned to the facility and Administrator A confirmed receipt of his/her diagnosis and change in condition on 01/26/2024 at 3:39 PM. Administrator A notified staff on 01/27/2024 at 12:48 PM, via the following progress note, "Resident was seen in the ED [emergency department] due to not feeling well. It was noted that [s/he] has Influenza A. [S/he] has returned back to the facility 01/26 same day. [S/he] has had a slight change in conditions with mobility. Staff to assist with transferring until further notice and for staff to encourage fluids."

On 01/30/2024, Surveyor requested to review Resident 3's record including, but not limited to, observation notes, physician communications and his/her current individual service plan (ISP).

Surveyor reviewed staff charting notes, which had the following entry related to a change in condition:

1/30/2024 14:18 Resident oxygen level was reading at 91, Hospice provided prn (as needed) oxygen at 2-6 liters. Staff to monitor for change in condition.

Surveyor reviewed the following hospice care notes in Resident 3's hospice binder:

01/29/2024: Pt was a 2 assist for all Adl's [sic] (a change from 1-assist documented on 01/26/2024). Writer assisted pt (patient) w/transfer to bed from recliner, repo, dressing, peri, oral, hair & incont care. Pt was incont (incontinent) of bladder. Writer updated RNCM (registered nurse case manager). Light

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	0014271	A. BUILDING: _____ B. WING _____	R-C 03/07/2024

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N 439	Continued From page 76 housekeeping done, garbage & laundry out. 01/30/2024: Lying in bed. nonproductive cough, agitated although just had PRN Lorazepam, refused, swatting at writer, told writer to just get out with your germs, [sic] agitation caused increase in cough so writer left. Report given to HM (house manager) [Administrator A]. On 01/30/2024 at approximately 6:10 PM, Surveyor interviewed Caregiver K and asked what Resident 3's current transfer status was for assistance. Caregiver K pulled up the task list for Resident 3 on the tablet s/he was using, which showed the following clinical alerts: 01/29/2024: Resident has a fever of 102.3 and will be guven [sic] an acetaminophen [sic] PRN to help try and bring it down a little. Staff will watch over [him/her] and continue to check [his/her] temp throughout the night. 01/30/2024: PRN was effective and fever has been brought down to 99.5, [sic] staff will continue to monitor. On 02/07/2024 at 3:19 PM, the Department received a self-report from Administrator A for an incident that occurred on 02/05/2024. The self-report identified Resident 6 had been found on the floor of his/her room, was transported to the hospital for further evaluation, and returned the same day with a diagnosis of Influenza A. The report further read, "Public Health was notified of positive Influenza A diagnosis. Appropriate isolation precautions have been put in place for staff to follow. Symptoms will be monitored closely and facility will notify MD (medical doctor) with any changes or concerns. Service Plan has been updated."	N 439		

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N 439	Continued From page 77 EXIT INTERVIEW: On 02/15/2024 at approximately 10:15 AM, Surveyor interviewed Administrator A and QA/FHM B. Administrator A stated the provider implemented a facility-wide resident symptom surveillance on 01/31/2024. In total, 5 residents (Resident 1, Resident 6, Resident 5, Resident 12, and Resident 13) were confirmed to have influenza and Resident 3 was suspected. Administrator A said 2 staff reported symptoms, Caregiver H and Caregiver E. Administrator A stated they reported the outbreak on 01/30/2024 and were working with local public health to ensure systems were in place to prevent the spread.	N 439		
N 441	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure Caregiver F followed hand washing procedures according to centers for disease control and prevention (CDC) standards during the morning medication pass on 01/30/2024. Findings include: On 01/30/2024 at 10:00 AM, Caregiver F entered Resident 1's room and administered 1 drop of Sodium Chloride 5% in both eyes. After administering the Sodium Chloride drops, Caregiver F checked Resident 1's blood pressure and administered Refresh Tears into both eyes;	N 441		

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N 441	Continued From page 78	N 441		

approximately 45 seconds after the Sodium Chloride drops. Caregiver F touched Resident 1's cheek with his/her bare hands to administer both eye drops.

Caregiver F returned to the medication cart outside Resident 1's room in the hallway, grabbed the medication keys and unlocked the cart. Caregiver F informed Surveyor Resident 1 had one more eye drop scheduled at 8:00 AM. Caregiver F retrieved the bottle of Prednisolone eye drops from the medication cart.

Surveyor asked Caregiver F if s/he administered the Sodium Chloride and Refresh Tears in both eyes. Caregiver F stated, "Yes, I did." Caregiver F read the label on the drops and informed Surveyor s/he did not read the labels. Caregiver F stated, "I'll be sure to only put this one (Prednisolone) in the left eye." Caregiver F closed the drawer, locked it, and entered Resident 1's room.

On 01/30/2024 at 10:03 AM, Caregiver F entered Resident 1's room and administered 1 drop into the left eye and administered Resident 1's inhaler. Caregiver F returned to the medication cart.

On 01/30/2024 at approximately 10:10 AM, Caregiver F prepared 5 pills for Resident 2, grabbed the Sarna lotion bottle and Symbicort. Caregiver F informed Surveyor Resident 2 was also prescribed "Vanicream" which was applied twice daily to legs. Caregiver F informed Surveyor the cream was in the medication cart but not on Resident 2's medication administration record (MAR). Caregiver F did not sanitize hands after completing Resident 1's medication pass.

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N 441	Continued From page 79 Caregiver F entered Resident 2's room, gave pills, administered the inhaler, donned one glove, and applied "Vanicream" to both legs, followed by the Sarna lotion. Caregiver F took off the glove, picked up the bottles of lotion, opened the medication cart with keys and placed them back in the cart. Caregiver F did not complete hand hygiene, wear gloves, or sanitize his/her hands prior to or after administering 3 different eye drops to Resident 1, prior to administering Resident 2's oral medication pass, and did not complete hand hygiene prior to or after applying cream to Resident 2's legs. On 01/30/2024 at approximately 10:40 AM, Surveyor discussed the lack of hand hygiene during the above observations with Caregiver F. Caregiver F stated, "Usually, I do sanitize in between every resident." Cross Reference N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0432 DHS 83.38(1)(h) Medication Administration	N 441		
Z 012	50.065(2)(bm) OUT OF STATE BACKGROUND CHECKS If the person who is the subject of the search under par. (am) or (b) is not a resident of this state or if at any time within the 3 years preceding the date of the search that person has not been a resident of this state, or if the department or entity determines that the person's employment, licensing, or state court records provide a	Z 012		

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Z 012	Continued From page 80 reasonable basis for further investigation, the department or the entity shall make a good faith effort to obtain from any state or other United States jurisdiction in which the person is a resident or was a resident within the 3 years preceding the date of the search information that is equivalent to the information specified in par. (am) 1. or (b) 1. The department or entity may require the person to be fingerprinted on 2 fingerprint cards, each bearing a complete set of the person's fingerprints. The department of justice may provide for the submission of the fingerprint cards to the federal bureau of investigation for the purposes of verifying the identity of the person fingerprinted and obtaining the records of his or her criminal arrests and convictions. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an out of state background check was conducted for Caregiver D when s/he completed the background information disclosure (BID) form with a Minnesota (MN) home address. Findings include: On 01/30/2024, Surveyor requested to review Caregiver D's record. The record contained a completed BID form, with a current address in MN listed for Caregiver D. The record did not contain evidence to show an out of state background check was conducted. On 01/30/2024, Surveyor asked Administrator A if an out of state background check was conducted	Z 012		

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Z 012	Continued From page 81 as Caregiver D had completed the BID form with a current home address in Minnesota. On 01/31/2024, Surveyor received an email from Quality Assurance/Float House Manager (QA/FHM) B that read, in part, "The second attachment is a MN background check for [Caregiver D]. After discussing with the Corporate Office, they do not pull MN background checks unless they check yes in the section B #3 on the BID document."	Z 012		