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 06/28/2024

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 06/05/2024, the Department conducted a complaint investigation and verification visit at Comforts of Home Hudson II. Data was collected through 06/28/2024. Three of 5 complaints were substantiated. Six violations were identified. Three of the 6 violations were repeat deficiencies. See Statement of Deficiency (SOD) 92G315, dated 03/07/2024; SOD 92G314, dated 07/11/2023; and SOD 92G311, dated 09/01/2021. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 30	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or	N 158		

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

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N 158	Continued From page 1	N 158		

misappropriation of property. The CBRF shall maintain documentation of any investigation.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not immediately safeguard residents from misconduct, investigate misconduct, or document an investigation of misconduct.

Lead Caregiver J witnessed Caregiver F mistreat residents (Resident 3, Resident 4, and Resident 6) and s/he did not immediately report or investigate the incidents.

Caregiver G reported concerns about Caregiver F's interactions with Resident 4 to Assistant House Manager (AHM) I and House Manager (HM) H around the beginning of April 2024; the provider did not document their investigation related to this allegation.

On 04/12/2024, concerns about Caregiver F were brought to Quality Assurance/Float House Manger (QA/FHM) B and Regional Director (RD) E and an investigation was initiated. The provider's investigation resulted in substantiated findings of abuse and Caregiver F's termination.

Findings include:

On 04/22/2024, the Department received a complaint related to caregiver misconduct.

On 06/05/2024, Surveyor requested the provider's misconduct investigations for March 2024 through June 2024.

Surveyor reviewed an internal investigation, dated 04/12/2024. The report read, "On 04/12/24 @

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N 158	Continued From page 2 6:32pm, [RD E] received a voicemail via email from [Attorney K], the attorney for [provider's name], in regard to abuse allegations against employee [Caregiver F]. The voicemail was left for [Attorney K] by [Detective L] with the Hudson Police Department stating that [Caregiver F] was accused of throwing residents in bed, swearing at them, and choking them. This voicemail was specified to [Resident 4] ... On 4/12/24, [Caregiver F] was working as a caregiver when VM [voicemail] was received. [AHM I] contacted [Caregiver F] and [s/he] was sent home and removed from the schedule, pending investigation ... All staff were interviewed, all residents who are their own person were interviewed ... Based off of interview conducted with resident [Resident 2], it was concluded that [Caregiver F] was displaying verbal/physical abuse towards [Resident 2] ... [Caregiver F's] employment was ended with [provider's name] on 4/13/24." Surveyor reviewed the statements collected during the investigation, which indicated Lead Caregiver J, AHM I, and HM H either witnessed or were alerted to Caregiver F's concerning behaviors prior to the investigation. Their statements, collected on 04/12/2024, read as follows: Lead Caregiver J wrote, "I [Lead Caregiver J] have witnessed [Caregiver F] doing pop a wheelies down the hall with [Resident 3] and [Resident 5]. Making snide comments like, 'If you keep asking the same questions I'm not going to [expletive] help you.' Told [Resident 4] you don't need to eat anymore cause your [sic] fat enough after [Resident 4] asking [sic] for more to eat. Falling asleep on [his/her] shifts even after being told multipol [sic] times to stay awake."	N 158		

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N 158	Continued From page 3 AHM I wrote, "On 4/12 at 6:41pm I got a phone call from my regional manager [RD E] to notify me that one of our Staff [Caregiver F] had been reported to the Hudson Police department [sic] for alleged Neglect [sic] on a resident. I was then told that I needed to have [him/her] clock out and leave the facility ... A former staff [Caregiver G] had told [HM H] and myself a week or two ago about a shift that [s/he] had worked with [Caregiver F] a while ag [sic] and stated that [s/eh] heard a resident yelling [Resident 4] why [sic] [Caregiver F] was caring for [him/her], when [Caregiver G] got to the room [s/he] stated that [s/he] didn't see anything out of the ordinary, Just [Caregiver F] caring for [him/her] ... [HM H] and myself called [Caregiver F] in and we had talked to [him/her] about what was brought to our attention and [s/he] told us [s/he] was trying to help [Resident 4] and was resisting the help." HM H wrote, "On 04/12/24 at 7pm it was reported to me [HM H] that there was a complaint against [Caregiver F] on possible neglect or abuse from my regional manager. I then explained to [him/her] that I had a conversation with a passed [sic] employee [Caregiver G] about a past shift [s/he] worked along with [Caregiver F]. [S/he] stated to me that [s/he] heard [Resident 4] screaming at him ([Caregiver F]) and [Caregiver G] went to the resident [sic] room and there was nothing out of ordinary going on ... [AHM I] and I then spoke with [Caregiver F] and [s/he] stated that [s/he] was helping [Resident 4] to bed/toileting [him/her]." Surveyor reviewed the provider's other investigation reports and did not find evidence these situations reported by Lead Caregiver J or Caregiver G were investigated.	N 158		

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N 158	Continued From page 4 On 06/19/2024 at approximately 12:15 PM, Surveyors interviewed QA/FHM B. QA/FHM B discussed the provider's internal investigation policy, stating caregivers were supposed to immediately report all concerns to the house manager, the house manager was supposed to consult with QA/FHM B, and they would begin the investigation immediately. Surveyors asked QA/FHM B if s/he was notified of any concerns related to Caregiver F prior to 04/12/2024. QA/FHM B stated, "[HM H] and [AHM I] did not notify me ... they should have." Surveyors asked if HM I or AHM I completed investigations related to Caregiver F. QA/FHM B stated s/he would review records and report back. On 06/20/2024 at 9:45 AM, Surveyor received an email from QA/FHM B that read, "There is no internal investigation on file for March or April completed by [AHM I]/[HM H]." According to Department records, the provider submitted a misconduct incident report to the Office of Caregiver Quality on 04/19/2024. Cross reference: N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment	N 158		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property.	N 348		

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N 348	Continued From page 5 This Rule is not met as evidenced by: Based on record review, the provider did not ensure Resident 2, Resident 3, Resident 4, and Resident 5 were free from abuse. Finding include: On 04/22/2024, the Department received a complaint regarding resident care and treatment. On 06/05/2024, Surveyor requested to review the provider's policy and procedure for caregiver misconduct and documentation of misconduct allegations recently investigated. On 06/05/2024, Surveyor reviewed the provider's "Misconduct-Abuse, Neglect and Misappropriation" policy and procedure, revised 04/23/2024. The policy and procedure defined abuse as, "Any act that negatively impacts the person's well-being (physical, emotional [sic] or material). Abuse may result by doing something or failing to do something that leads to a negative impact on an individual." On 06/05/2024, Surveyor reviewed misconduct investigations provided by Quality Assurance/Float House Manger (QA/FM) B. On 04/13/2024 at 10:14 AM, Resident 2 reported being abused by Caregiver F during an interview with QA/FM B. According to the allegations, Caregiver F "yanked" the remote out of Resident 2's hands to help him/her. Once done fixing the television, Resident 2 stated to Caregiver F, "I could have done that." Caregiver F replied with, "[Resident 2], can you quit your [expletive]; you	N 348		

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always do this [expletive]. I wiped your [expletive] today, next time you can sit in your [expletive] because I am not helping you." Resident 2 stated s/he replied by calling Caregiver F an [expletive]. Caregiver F then called Resident 2 a [expletive]. During the interview, Resident 2 also stated Caregiver F was rough with him/her during personal cares and stated that when Caregiver F is angry with him/her, Caregiver F would push on his/her knees and legs harder.

The provider's investigation report included a written statement from Lead Caregiver J that read, "I [Lead Caregiver J] have witnessed [Caregiver F] doing pop a wheelies [sic] down the hall with [Resident 3] and [Resident 5]. Making snide comments like, '[sic] If you keep asking the same question I'm not going to [expletive] help you.' [sic] Told falling asleep [sic]. Told [Resident 4], "You don't need to eat anymore cause your [sic] fat enough after [him/her] (Resident 4) asking for more to eat. Falling asleep on [his/her] shift even after being told multipol [sic] times to stay awake."

QA/FM B interviewed the alleged caregiver (Caregiver F) as part of the internal investigation. Documentation of this interview read, "Spoke with [Caregiver F] via phone call on 04/13/2024 @ 9:24am. Writer explained the allegations against [him/her] during this phone call. [Caregiver F] stated that [s/he] would never hurt anyone or choke anyone. [S/he] admitted that [s/he] does tend to get frustrated at times, but never towards the residents. Writer asked if management has had conversations with [him/her] regarding any concerns during [his/her] employment at [facility name]. [S/he] said yes. When asked to explain, [s/he] said [s/he] was written up by [Person M] for talking loud/shouting at a resident. [S/he]

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N 348	Continued From page 7 explained that during that incident, [s/he] was talking loud/shouting at the resident due to hearing impairments + (and) didn't think the resident could hear [him/her]. [S/he] also stated that management has spoken to [him/her] regarding cussing, [sic] and sleeping during scheduled shift." Based on the internal investigation report, Caregiver F had a pattern of concerning behaviors during his/her employment, as evidenced above. Caregiver F had a hire date of 02/22/2023 and was employed for approximately 14 months to care for residents. The provider's investigation summaries, dated 04/13/2024 and 04/17/2024, determined the allegations/interview from Resident 2 regarding Caregiver F were substantiated for displaying verbal/physical abuse, and the interview with Lead Caregiver J confirmed witnessed verbal abuse. Caregiver F was terminated on 04/13/2024. Cross Reference N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse and Neglect	N 348		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not implement Resident 2's individual service plan (ISP) as written.	N 388		

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N 388	Continued From page 8 This is a repeat deficiency. See Statement of Deficiencies (SOD) 92G314, dated 07/11/2023. Between March 2024 and May 2024, the Department received multiple complaints related to resident care. On 06/05/2024 at 9:10 AM, Surveyor interviewed Resident 2. Resident 2 stated s/he needed assistance with most everything, including transfers via Hoyer lift, dressing, incontinence care, and bathing. Resident 2 stated his/her services had improved in the past month but things "could not have been worse" before this. Resident 2 stated staff would routinely transfer him/her to his/her "torture chair" (Broda chair) and leave him/her in the middle of his/her room for hours at a time. Resident 2 stated s/he was in his/her chair for over 14 hours one day with the door shut and his/her call light out of reach. Resident 2 said, "It got to the point that I didn't want to get into the chair... they'd put the brakes on, and I can't reach them... they'd get mad because I'd be yelling... I got a sore throat from yelling. Now I tell them to leave the door open so they can hear me... I got pressure sores from it." Resident 2 said s/he had orders from his/her physician that s/he cannot be in his/her Broda chair for more than 3 hours at a time. Resident 2 said s/he spoke with a past manager about his/her concerns. Resident 2 said hospice was supposed to give Resident 2 his/her weekly shower but there were times when hospice did not come. Resident 2 said s/he would ask staff to give him/her a shower "but they say they are too busy." Resident 2 said s/he had gone weeks without a shower in the past.	N 388		

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N 388	Continued From page 9 Surveyor reviewed the provider's shower schedule, which indicated Resident 2's scheduled showers twice a week, on Mondays and Thursdays. At 1:35 PM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 2 was scheduled to receive 1 hospice shower per week and 1 provider shower per week. Caregiver D said Resident 2 preferred evening showers and if s/he refused, staff were supposed to make 3 attempts before documenting it as a refusal in Resident 2's chart. Caregiver D stated caregivers documented if tasks were offered and refused or completed. On 06/05/2024 and 06/11/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 03/29/2023 and admitted to hospice services on 10/30/2023. Resident 2's ISP read: - "Has a history of pressure sores." Section added to his/her ISP on 06/23/2023. - "Resident is dependent with all ambulation and will need staff to move [him/her] to/from all areas." Revised 03/27/2024. - "Requires assistance from 2 staff with all transfers via hoyer [sic] lift. [S/he] uses a broda [sic] chair with mobility and is unable to self-propel." Revised 03/27/2024. - Staff to assist resident with all bathing tasks/process to ensure cleanliness. Resident requires total assistance with bathing and is unable to assist with task... Resident is scheduled to showers twice a week, may refuse showers." Revised 12/01/2023. - "Requires assistance from 1 staff with showering, on days of refusals [s/he] may allow staff to assist with a bed bath." Intervention initiated 04/10/2024 and revised 05/21/2024.	N 388		

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N 388	Continued From page 10 - "Safety Check: Every 2 hours." Initiated 06/27/2023. - "TURN AND REPOSITION: Reposition every 2 hours while in bed or in wheelchair (tilting 6 inches forward or backward)." This intervention was added on 02/26/2024. Resident 2's task administration record for 05/13/2024 through 06/05/2024 suggested Resident 2 did not receive repositioning or safety checks per his/her ISP. For example, Staff documented that on 05/13/2024, Resident 2 was repositioned at 6:05 AM, checked on at 10:58 AM and 5:54 PM, and repositioned again at 6:38 PM. Resident 2 went nearly 12 hours between positionings. On 05/14/2024, Resident 2 was repositioned and checked at 2:38 AM, checked on at 10:05 AM, and repositioned at 10:54 AM. Resident 2 went approximately 8 hours between positionings. On 05/25/2024, Resident 2 was repositioned at 6:03 AM, checked on at 10:00 AM and 11:05 AM, and repositioned at noon. Resident 2 went approximately 6 hours between positionings. On 05/30/2024, Resident 2 went approximately 4 hours between repositioning and safety checks; repositioned at 10:57 AM, checked on 2:00 PM, repositioned at 2:14 PM. In the evening on 05/30/2024, Resident 2 went another 4 hours between checks and repositioning. None of these examples included evidence that the service was offered and refused. A progress note dated 05/03/2024 read, "Resident stated that [s/he] did not want to get up this early because [s/he] 'didn't want to be in [his/her] broda [sic] chair for 12 hours.'" House Manager (HM) A responded, "Reviewed; Resident should not be in chair for 12 hours. [S/he] would get up in the morning for breakfast and then staff could reposition [him/her] to	N 388		

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N 388	Continued From page 11 [his/her] bed prior to lunch." Surveyor reviewed Resident 2's shower documentation for April 2024 and May 2024, which suggested Resident 2 had not received 2 weekly showers per his/her ISP. Staff were able to document if the task was completed, not completed, "resident not available," "resident refused," or "not applicable." staff documented Resident 2's showers as follows: 04/03/2024 - not completed. 04/07/2024 - refused. 04/10/2024 - not applicable. 04/14/2024 - refused. 04/17/2024 - not completed. 04/21/2024 - completed. 04/24/2024 - completed. 04/28/2024 - completed. 05/06/2024 - blank, no documentation. 05/13/2024 - blank, no documentation. Progress notes indicated morning staff completed a bed bath. 05/20/2024 - blank, no documentation. 05/23/2024 - completed. 05/27/2024 - refused. 05/30/2024 - completed. On 06/19/2024 at 11:00 AM, Surveyor interviewed HM A and Quality Assurance/Float Manager (QAFHM) B. Both managers stated Resident 2 was a reliable reporter, alert and orientated. QAFHM B stated Resident 2's hospice aid visited Resident 2 weekly. Resident 2 received 1 shower from caregivers and 1 shower from hospice weekly. QAFHM B stated s/he believed Resident 2 received services per his/her ISP because s/he had not heard any concerns from Resident 2. QAFHM B and HM A reviewed staff charting which suggested Resident 2 had not received services per his/her ISP and stated they would	N 388		

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N 388	Continued From page 12 investigate the situation. QAFHM B stated s/he was not aware Resident 2 was being left in his/her Broda chair for extended periods of time. HM A stated s/he first heard of this concern on 05/03/2024 and s/he provided education to staff in the progress note (referenced above).	N 388		
{N 431}	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.	{N 431}		

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	0014271	A. BUILDING: _____ B. WING _____	R-C 06/28/2024

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{N 431}	Continued From page 13 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 2 received health monitoring services. Resident 2's physician was not notified when Resident 2's blood glucose and blood pressure were outside parameters as indicated in Resident 2's treatment orders. This is a repeat deficiency. See Statement of Deficiencies (SOD) 92G315, dated 03/07/2024, and SOD 92G311, dated 09/01/2021. Findings include: On 04/10/2024, the Department issued a notice and order letter with SOD 92G315 that read: "1. 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 83.14(2)(a) and ensure that the CBRF and its operation comply with this chapter and with all other laws governing the CBRF and its operation. The licensee shall develop and implement corrective measures to resolve each deficiency identified in Statement of Deficiency (SOD) 92G315. WITHIN 45 DAYS of receipt of this notice, the licensee's corrective measures shall include the development (or review/revision) of written procedures to address, at a minimum: Health Monitoring: Including how the facility will: (a) monitor and document changes in the resident's physical or	{N 431}		

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{N 431}	Continued From page 14 mental health; (b) notify the resident's legal representative and care manager (if any) when a resident experiences a change of condition, accident, injury, or medical emergency; (c) obtain timely medical care (clinical assessments, medications, prompt medical treatment), and (d) provide or arrange services to address each resident's health care needs... Additionally: - All managers and resident care staff (as appropriate) will receive in-service training regarding the provider's written procedures required by Order #1." On 06/05/2024, Surveyor reviewed the provider's written procedures and training documentation, which indicated the health monitoring procedures had been revised and staff training was completed on 04/30/2024. On 06/05/2024 at 11:18 AM, Surveyor interviewed Quality Assurance/Float Manager (QAFHM) B. QAFHM B stated staff documented all communication with resident physicians in progress notes. On 06/05/2024 and 06/11/2024, Surveyor reviewed Resident 2's records. Resident 2 was admitted to the facility on 03/29/2023 and admitted to hospice services on 10/30/2023. Resident 2's record included an order for daily blood glucose monitoring with instructions to notify Resident 2's physician if Resident 2's blood glucose was below 90. Resident 2 also had an order for daily blood pressure monitoring with instructions to alert his/her physician if systolic readings were below 100 or above 180 or if Resident 2 was symptomatic (order dated	{N 431}		

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{N 431}	Continued From page 15 05/26/2023). According to Resident 2's medication administration record (MAR) for dates 04/01/2024 through 05/31/2024, Resident 2's blood glucose was outside parameters on the following dates: - 04/03/2024, 72 mg/dL - 04/08/2024, 84 mg/dL - 05/21/2024, 80 mg/dL Resident 2's blood pressure was outside parameters on the following dates: - 05/23/2024, 93/63 - 05/27/2024, 93/61 - 05/31/2024, 93/62 Surveyor reviewed Resident 2's progress notes and did not find evidence that Resident 2's physician was notified when Resident 2's vitals were outside the parameters. On 06/19/2024 at 11:00 AM, Surveyor interviewed House Manager A and QAFHM B. QAFHM B reviewed Resident 2's record and was not able to find evidence Resident 2's physician was notified when his/her vitals were outside the parameters. QAFHM B stated s/he would continue to review Resident 2's charting and send documentation to Surveyor via email. As of 06/28/2024, Surveyor had not received additional documentation.	{N 431}		
{N 441}	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and prevention standards.	{N 441}		

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{N 441}	Continued From page 16 This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure 2 caregivers (Caregiver C and Caregiver D) performed hand washing procedures in accordance with the Centers for Disease Control and Prevention (CDC) standards, on 06/05/2024. This is a repeat deficiency. See Statement of Deficiencies (SOD) 92G315, dated 03/07/2024. Findings include: According to information found on https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, "Clinical Safety: Hand Hygiene for Healthcare Workers" healthcare personnel should use alcohol-based hand rub or wash with soap and water for the following clinical indications: - Immediately before touching a patient - Before performing an aseptic task or... handling invasive medical devices - Before moving from work on a soiled body site to a clean body site on the same patient - After touching a patient or the patient's immediate environment - After contact with blood, body fluids, or contaminated surfaces - Immediately after glove removal On 06/05/2024 at 9:30 AM, Surveyor observed Caregiver C and Caregiver D perform an incontinence brief change on Resident 1. The task included transferring Resident 1 from wheelchair to bed, removing Resident 1's soiled brief and clothing, performing peri care, redressing Resident 1, and transferring Resident 1 back to his/her wheelchair. Surveyor observed	{N 441}		

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{N 441}	Continued From page 17 the caregivers change their gloves multiple times throughout the task. The caregivers left Resident 1's room at 9:56 AM. Neither caregiver performed hand hygiene during the care task. At 9:57 AM, Surveyor interviewed Caregiver C. Caregiver C acknowledged that s/he should have washed or sanitized his/her hands between glove changes. On 06/05/2024, Surveyor reviewed the provider's written infection control and hand washing procedures (revised 05/18/2016) which read, "Indications for hand washing include, but are not limited to: ... After contact with body secretions... between activities on the same resident involving different body sites... Before you don gloves or after you remove gloves."	{N 441}		
Y3237	50.09(1)(f)2. Privacy Health Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (f) Physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including, but not limited to: 2. Privacy concerning health care. Case discussion, consultation, examination and treatment are confidential and shall be conducted discreetly. Persons not directly involved in the resident's care shall require the resident's permission to	Y3237		

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Y3237	Continued From page 18 authorize their presence This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure Resident 1 was given privacy on 06/05/2024. Caregiver C and Caregiver D performed Resident 1's incontinence care in Resident 1's room without drawing the privacy shade. Residents on the patio had a clear view of Resident 1 during the care task. Findings include: On 06/05/2024 at 9:30 AM, Surveyor observed Caregiver C and Caregiver D perform an incontinence brief change on Resident 1. The task included transferring Resident 1 from his/her wheelchair to bed, removing Resident 1's soiled brief and clothing, performing peri care, redressing Resident 1, and transferring Resident 1 back to his/her wheelchair. Surveyor observed multiple residents on a patio directly outside Resident 1's window while caregivers were performing care on Resident 1. The residents appeared to have a clear view of Resident 1's room and Resident 1's treatment. At approximately 9:40 AM, Surveyor asked Caregiver D about the patio outside Resident 1's window. Caregiver D stated it was the provider's main patio, which residents were able to access freely from the dining room. Caregiver D said the patio included the resident smoking area and raised gardens.	Y3237		

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Y3237	Continued From page 19 The caregivers completed Resident 1's care at 9:56 AM and left his/her room. Resident 1's blinds remained open throughout the observation. At 9:57 AM, Surveyor asked to speak with Caregiver C. Caregiver C immediately stated, "The blinds." Caregiver C said s/he normally shut Resident 1's window blinds during cares because residents on the patio could see into Resident 1's room.	Y3237		