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	0011953	A. BUILDING: _____ B. WING _____	C 06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS STEVENS POINT 1	3349 BUILDING A WHITING AVENUE STEVENS POINT, WI 54481

(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 with additional information gathered through 06/10/2024, Surveyor conducted a self-report and complaint investigation at Care Partners Stevens Point 1. As a result the complaint was substantiated. A total of four (4) deficiencies were identified. Two (2) of the four (4) deficiencies were repeat cites. Census: 7	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not take steps to ensure the safety of	N 158		

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

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N 158	Continued From page 1 all residents, thoroughly investigate, and maintain documentation of the investigation in response to a report received which alleged potential neglect and/or mistreatment of a resident. On 05/24/2024 upon arrival for the AM shift, Caregiver B and Caregiver D found Resident 1 on the floor in her/his room calling for help. Resident 1 alleged s/he fell out of bed at 3 AM, was calling for help throughout the night and staff ignored her/his cries. When Caregiver B and Caregiver D found Resident 1 on the floor neither Caregiver B nor Caregiver D called the Director, Regional Nurse or an ambulance. Resident 1 laid on the floor until Director A reported to work at 8 AM. After learning of the concern, the provider did not conduct or document a thorough investigation into the incident or put measures into place to protect all residents pending the conclusion of the investigation. This is a repeat deficiency being cited for the third time. See Statement of Deficiency (SOD) 5MV212, dated 02/25/2021, and SOD 5MV215, dated 08/16/2023. Findings include: The provider is licensed to serve up to 16 non-ambulatory residents from the following client groups; irreversible dementia/Alzheimer's, terminally ill, physically disabled or advanced age. The facility is located on the same grounds as Care Partners Stevens Point 2 (a sister facility with a paved parking lot located between the two facilities). On 05/28/2024, the Department received a complaint alleging potential neglect to a resident.	N 158		

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N 158	Continued From page 2 An APS (Adult Protective Services) report dated 05/24/24, indicated, "[Detective C] heard an ambulance call to the facility, EMS was informed [Resident 1] had two falls overnight and had been on the floor in [her/his] room since 3 AM. Ambulance was contacted a little after 8 AM. Met [Detective C] at facility at 11:30 AM. Staff on the floor included [Caregiver B] and [Caregiver D]... [Caregiver B] stated [s/he] found [Resident 1] on the floor in [her/his] room as [s/he] heard [Resident 1] screaming as the night shift was leaving. [Resident 1] told [Caregiver B] [s/he] had fallen 2 times last night and had been on the floor since 3 AM. [Caregiver B] stated [s/he] put down more pillows. When asked why [s/he] hadn't called the ambulance, [s/he] said [Caregiver D] told [him/her] not too...[Caregiver B] said they didn't have enough workers to get [Resident 1] into the ambulance...[Caregiver B] stated although [s/he] thought an ambulance should be called, [s/he] did not call one, and [s/he] continued to go to the other house and help them with breakfast and did not come back until [Director A] came in. Per [Caregiver B], [Resident 1] yelled for help about every 40 minutes, and [s/he] would go in [her/his] room to try to comfort [her/him] and tell [her/him] they would be calling for help. Per [Caregiver B], [Caregiver D] stayed at the building where [Resident 1] was and only went to [Resident 1] when [s/he] first went to [her/him] to tell [her/him] that [Resident 1] was on the floor...[Caregiver B] stated, "I should've just called the ambulance and not let other staff tell me what to do" ...Spoke to [Caregiver D] with [Director A] and [Detective C] and [Caregiver D] denied telling [Caregiver B] not to contact the ambulance, however, admitted [s/he] did not call an ambulance and stated [s/he] had called [Director A]. Per [Director A] [s/he] received a call around 6:37 AM and it was regarding one of the	N 158		

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morning staff not showing up, and nothing regarding the fall. [Caregiver D] admitted to doing nothing to assist [Resident 1] from the time [s/he] came in at 6 AM to 8 AM...[Caregiver D] said when [Caregiver B] went to get [her/him], [s/he] saw [Resident 1] lying on the floor covered with a blanket and with a pillow under [her/his] head. Per [Caregiver D], [Resident 1] did not express pain and told [her/him] that [s/he] had been on the floor since 3 AM. [Caregiver D] said [s/he] didn't want to move [Resident 1] and couldn't lift [her/him] and felt they didn't have enough staff. [Caregiver D] said [s/he] thought [Caregiver B] was going to call the ambulance but did not check to see if [s/he] had and said, "We should've called them." When I asked [Caregiver D] why [s/he] didn't call, [s/he] said "You're right"...The other night shift worker [Caregiver F] called [Director A] while we were with [Director A] and stated it was a stressful night last night and [s/he] was working at the memory care building. [Caregiver F] said [s/he] was told [Caregiver E] had to use the Hoyer lift last night after [Resident 1] fell. [Caregiver F] received a text from [Caregiver E] at about 1:48 AM but did not get another text about another fall. [Caregiver F] said [s/he] was told [Resident 1] had been trying to self-transfer..."

On 06/05/2024, Surveyor reviewed Resident 1's medical record. Resident 1 was admitted to the facility on 11/23/2023 with diagnoses to include diabetes and heart failure. Resident 1 was his/her own person, able to make her/his needs known and was very pleasant. Resident 1's ISP dated 12/10/2023, indicated the resident has a call light button, a fall mat at bedside, a wheelchair for mobility and required assistance with grooming, bathing, and toileting. Additionally, the ISP indicated Resident 1

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required a Hoyer lift for all transfers, with the assistance of two staff and noted, "[Resident 1] is not bearing much weight on legs."

The Department received a facility self-report on 05/30/2024 which indicated, "On 05/24/2024 at 3:00 AM [Resident 1] accused caregiver of ignoring [her/his] need for help. Resident had no injury. Threw investigation this resident does at times make up things." (Surveyor noted Resident 1's ISP was silent to any type of behavior related to making untrue statements, lying, or making things up.) The Department also received an MIR (Misconduct Incident Report) on 06/05/2024 which indicated, "On 05/24/2024 at 6:00 AM, during 6 AM med pass, caregiver found [Resident 1] on floor in [her/his] room. [Resident 1] claimed [s/he] had been on the floor since 3 AM. Caregiver provided pillows for comfort until resident could be sent out. Staff did not immediately update Director. [Resident 1] reported pain to caregiver at 6 AM. Staff notified Director upon entrance to facility at 8 AM. Director immediately checked on resident and sent [her/him] out via ambulance for ER evaluation. Director immediately contacted all involved staff for that building, obtained written statements and updated Regional Nurse." Surveyor noted Regional Nurse H prepared and signed the MIR.

Both the facility self-report and MIR contained an incident report for Resident 1, an ED (Emergency Department) after visit summary, and written statements from 5 staff members. Surveyor reviewed all documents and noted the following:

*Resident 1's incident report indicated, "On 05/24/2024 at 3 AM, when passing meds staff noticed [Resident 1] was on the floor by [her/his]

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chair. [Resident 1] told us this was the second time tonight. Pillow behind back and legs and waited till we could call an ambulance..."

*Resident 1's ED after visit summary indicated, "Resident 1 was seen on 05/24/2024 with diagnoses of a fall and knee contusion, with no acute fracture."

*The 5 staff members written statements were dated 05/24/2024 and indicated the following:

-Caregiver E (who worked the night shift alone on 05/23/2024) stated s/he put Resident 1 to bed at 2:30 AM and checked on the resident at 3:15 AM and again around 4:30 AM-5:00 AM and the resident was asleep.

-Caregiver D (who worked the AM shift on 05/24/2024) stated s/he came into work and noticed Resident 1 on the floor. Caregiver D asked Resident 1 how long s/he was on the floor the resident said s/he had been on the floor since 3 AM and had been ignored.

-Caregiver B (who worked the AM shift on 05/24/2024) stated upon his/her arrival, night shift left, and crying was heard from Resident 1's room. Caregiver B offered to call an ambulance, but Caregiver D told Caregiver B to wait. Caregiver B placed a pillow on the side Resident 1 was in pain and when Director A arrived an ambulance was called.

-Director A stated s/he arrived on 05/24/2024 at 8 AM and was told by Caregiver B, Resident 1 was on the floor since 3 AM. Director A went to Resident 1's room. Resident 1 complained of right hip, shoulder, and arm pain. Caregiver B called an ambulance. Resident 1 stated s/he had

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fell one other time and Caregiver E and Caregiver F helped with a Hoyer lift. The second time Resident 1 fell out of bed s/he yelled for help and stated s/he was ignored.

-Caregiver G stated s/he arrived on 05/24/2024 at 8:14 AM and Caregiver B was on the phone with EMS. Caregiver G went into the room with Director A and Resident 1 was laying on the floor by the recliner. Resident 1 stated s/he had fallen twice last night; the first time Caregiver E helped her/him, but the second time s/he fell Caregiver E didn't come. Resident 1 had been yelling for help since 3 AM. Resident 1 reported being in pain and receiving no medication. Caregiver G administered pain medication at 8:20 AM. Caregiver G's written statement also revealed Resident 1's fall mat was still underneath the bed and not in use.

On 06/05/2024 at 9:30 AM, Surveyor interviewed Director A regarding the above allegation and facility self-report/MIR. Director A stated, "Nothing was done until I came in at 8 AM on 05/24/2024. I received no phone call, text, nothing. I have no idea why staff didn't call me for direction. When I started, I told staff to call me with any concerns and posted my phone number in the med room...This was my first time dealing with an allegation of misconduct." Director A confirmed Caregiver E worked alone in the building during the night shift and Caregiver F was working alone in the sister facility. Surveyor then ask if s/he had any additional information other then the five written staff statements, the incident report, and the ED after visit summary. Director A verified s/he provided all documented information to Surveyor, and no further documentation was available. Director A stated, "No one in management is helping with the

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investigation and there's been no direction from them...Management just tells me to send the information I have, and they will send it to the state."

Surveyor noted the documented investigation did not include:
---the steps that were taken to ensure the health, safety and well-being of the residents
---Resident 1's interview and explanation of the allegations and any effects they may have had on the resident
---information fall prevention interventions were in place and being used for Resident 1
---information indicating if Resident 1's call light was within reach and working properly
---information indicating residents were interviewed to determine if their needs were met or if they had experienced similar incidents.
---information an interview was attempted or completed with Caregiver F, who worked in the sister facility during the alleged incident and reported to have known and/or helped Resident 1 with a fall.
---the conclusion of the investigation

On 06/05/2024 at 11:00 AM, Director A verified the investigation did not include any of the above information. Director A confirmed the conclusion to the investigation was not complete and stated, "I plan to discuss this incident with [Regional Nurse H] today." Director A also confirmed all three Caregivers involved in this incident (Caregiver B, D and E) continued to work and provide direct resident care after s/he learned of the allegation, and prior to the conclusion of the investigation. Director A then stated, "A few residents recently reported to me (06/03/2024), [Caregiver E] ignores them when they put their call light on and [s/he] will turn it off and not help.

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N 158	Continued From page 8 [Caregiver E] does not toilet or change residents and sits on [his/her] butt at night with the TV turned up loud...I'm going to talk to [Regional Nurse H] today about letting [Caregiver E] go...I know we would be short staffed, but I would rather be short staffed than have the residents go through this." Director A went on to say, "I did write up the three staff who were involved in this incident (Caregiver B, D and E) for not following the policy when [Resident 1] fell out of bed and they didn't provide [her/him] with prompt and adequate treatment. I've only been able to re-educate and go over the written warning notice with [Caregiver D]. I haven't had a chance to bring in [Caregiver B and E] to re-educate them or talk about their warning notice...I'm planning on holding a mandatory all staff meeting on 06/20/2024 to go over the policies on Resident Rights, Abuse/Misconduct and Illness/Injury/Change of Condition." On 06/05/2024 at 2:00 PM, Surveyor conducted an exit interview with Director A and Regional Nurse H. Surveyor requested all the facility's documented investigation into the above allegation on 05/24/2024. Director A and Regional Nurse H verified they were aware of the allegation and had no additional information or documentation regarding the incident. Cross Reference: N0348 DHS 83.12(2) 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	N 348		

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N 348	Continued From page 9 physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on interviews and record review, the provider did not ensure Resident 1 was free from neglect. On 05/24/2024 upon arrival for the AM shift, Caregiver B and Caregiver D found Resident 1 on the floor in her/his room calling for help. Resident 1 alleged s/he fell out of bed at 3 AM, was calling for help throughout the night and was ignored by Caregiver E. When Caregiver B and Caregiver D found Resident 1 on the floor at 6 AM, neither Caregiver B nor Caregiver D called the Director, Regional Nurse, or an ambulance. Resident 1 laid on the floor until Director A reported to work at 8 AM. Consequently, Resident 1 experienced pain in her/his right hip, shoulder/arm and knee and was sent to the ED (Emergency Department) for evaluation. 83.02(31) "Neglect" has the meaning as given in s. 46.90 (1) (f), Stats: The failure of a caregiver, as evidenced by an act, omission, or course of conduct, to endeavor to secure or maintain adequate care, services, or supervision for an individual, including food, clothing, shelter, or physical or mental health care, and creating significant risk or danger to the individual's physical or mental health. This is a repeat deficiency being cited for the second time. See SOD 5MV215 dated	N 348		

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N 348	Continued From page 10 08/26/2023. Findings include: The provider is licensed to serve up to 16 non-ambulatory residents from the following client groups; irreversible dementia/Alzheimer's, terminally ill, physically disabled or advanced age On 05/28/2024, the Department received a complaint alleging potential neglect to a resident. The Department received a facility self-report on 05/30/2024 which indicated, "On 05/24/2024 at 3:00 AM [Resident 1] accused caregiver of ignoring [her/his] need for help. [Resident 1] had no injury. Threw investigation this resident does at times make up things." (Surveyor noted Resident 1's ISP was silent to any type of behavior related to making untrue statements, lying, or making things up.) The Department also received an MIR (Misconduct Incident Report) on 06/05/2024 which indicated, "On 05/24/2024 at 6:00 AM, during 6 AM med pass, caregiver found [Resident 1] on floor in [her/his] room. [Resident 1] claimed [s/he] had been on the floor since 3 AM. Caregiver provided pillows for comfort until resident could be sent out. Staff did not immediately update Director. [Resident 1] reported pain to caregiver at 6 AM. Staff notified Director upon entrance to facility at 8 AM. Director immediately checked on resident and sent [her/him] out via ambulance for ED evaluation ..." An APS (Adult Protective Services) report dated 05/24/2024, indicated, "[Detective C] heard an ambulance call to the facility, EMS (Emergency Medical Services) was informed [Resident 1] had two falls overnight and had been on the floor in	N 348		

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N 348	Continued From page 11 [her/his] room since 3 AM. Ambulance was contacted a little after 8 AM. Met [Detective C] at facility at 11:30 AM. Staff on the floor included [Caregiver B] and [Caregiver D]...[Caregiver B] stated [s/he] found [Resident 1] on the floor in [her/his] room as [s/he] heard [Resident 1] screaming as the night shift staff was leaving. [Resident 1] told [Caregiver B] [s/he] had fallen 2 times last night and had been on the floor since 3 AM. [Caregiver B] stated [s/he] put down more pillows. When asked why [s/he] hadn't called the ambulance, [s/he] said [Caregiver D] told [him/her] not too...[Caregiver B] said they didn't have enough workers to get [Resident 1] into the ambulance. Per [Caregiver B], [Resident 1] also told [him/her] [Caregiver E] who worked night shift told [Resident 1] that "[S/he] was not playing [Resident 1's] games tonight" referencing the night before and [Caregiver E] didn't like [her/him]. [Resident 1] said [Caregiver E] would not respond to [her/him] screaming for help. [Resident 1] also stated [Caregiver E] yelled and cursed at [her/him] and thinks [Caregiver E] is sick of [her/him]. [Caregiver B] stated [s/he] thinks [Caregiver E] has some anger towards [Resident 1]. [Caregiver B] stated although [s/he] thought an ambulance should be called, [s/he] did not call one, and [s/he] continued to go to the other house and help them with breakfast and did not come back until [Director A] came in. Per [Caregiver B], [Resident 1] yelled for help about every 40 minutes, and [s/he] would go in [her/his] room to try to comfort [her/him] and tell [her/him] they would be calling for help. Per [Caregiver B], [Caregiver D] stayed at the building where [Resident 1] was and only went to [Resident 1] when [s/he] first went to [her/him] to tell [her/him] that [Resident 1] was on the floor...[Caregiver B] stated, "I should've just called the ambulance and not let other staff tell me what to do." Per	N 348		

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N 348	Continued From page 12 [Caregiver B], [Resident 1] had only a depend on. Spoke with [Resident 1] and [s/he] validated [Caregiver B's] statements, stating [Caregiver E] does not like [her/him] and [s/he] would not respond to [her/him] screaming for help. [Resident 1] said [s/he] yelled so many times and no one came to help [her/him] until [Caregiver B] came in. [Resident 1] was happy to see [Caregiver B] and said [s/he] is always helpful, but [Caregiver E] does not like [her/him]. [Director A] came in and said [s/he] was not notified of the fall at all last night, not until 8 AM when [s/he] got into the office. [Director A] said [Caregiver B] then came to the office and told [Director A] [Resident 1] had been on the floor and inquired if [s/he] should call the ambulance. [Director A] then said [s/he] told [Caregiver B] to call the ambulance immediately...The other night shift worker [Caregiver F] called [Director A] while we were with [Director A] and stated it was a stressful night last night and [s/he] was working at the memory care building. [Caregiver F] said [s/he] was told [Caregiver E] had to use the Hoyer lift last night after [Resident 1] fell. [Caregiver F] received a text from [Caregiver E] at about 1:48 AM but did not get another text about another fall. [Caregiver F] said [s/he] was told [Resident 1] has been trying to self-transfer. Spoke to [Caregiver D] with [Director A] and [Detective C] and [Caregiver D] denied telling [Caregiver B] not to contact the ambulance, however, admitted [s/he] did not call an ambulance and stated [s/he] had called [Director A]. Per [Director A] [s/he] received a call around 6:37 AM and it was regarding one of the morning staff not showing up, and nothing regarding the fall. [Caregiver D] admitted to doing nothing to assist [Resident 1] from the time [s/he] came in at 6 AM to 8 AM...[Caregiver D] said when [Caregiver B] went to get [her/him], [s/he] saw [Resident 1] lying on the floor covered	N 348		

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with a blanket and with a pillow under [her/his] head. Per [Caregiver D], [Resident 1] did not express pain and told [her/him] that [s/he] had been on the floor since 3 AM. [Caregiver D] said [s/he] didn't want to move [Resident 1] and couldn't lift [her/him] and felt they didn't have enough staff. [Caregiver D] said [s/he] thought [Caregiver B] was going to call the ambulance but did not check to see if [s/he] had and said, "We should've called them." When I asked [Caregiver D] why [s/he] didn't call, [s/he] said "You're right"..."

On 06/05/2024, Surveyor reviewed Resident 1's medical record. Resident 1 was admitted to the facility on 11/23/2023 with diagnoses to include diabetes and heart failure. Resident 1 was his/her own person, able to make her/his needs known and was very pleasant. Resident 1's ISP dated 12/10/2023, indicated the resident has a call light button, a fall mat at bedside, a wheelchair for mobility and required assistance with grooming, bathing, and toileting. Additionally, the ISP indicated Resident 1 required a Hoyer lift for all transfers, with the assistance of two staff and noted, "[Resident 1] is not bearing much weight on legs."

An incident report for Resident 1 dated, 05/24/2024 at 3 AM indicated, "When passing meds staff noticed [Resident 1] was on the floor by [her/his] chair. [Resident 1] told us this was the second time tonight. Pillow behind back and legs and waited till we could call an ambulance."

An ED after visit summary for Resident 1 dated 05/24/2024 indicated, "[Resident 1] was seen for Trauma with diagnoses of a fall and knee contusion, with no acute fracture.

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N 348	Continued From page 14 On 06/05/2024 at 11:40 AM, Surveyor interviewed Resident 1 in her/his room. Resident 1 indicated s/he required assistance from staff and stated, "I use my call button all the time for help. The other night I fell out of bed when [Caregiver E] was working and [s/he] never checked on me or answered me when I called out for help. When I fell, I hit bad...I laid on the floor for at least five hours. My right knee, arm and shoulder hurt bad, and I was in pain. I pressed my call button five or six times and yelled for help, but no one came. I couldn't get to my cell phone, but I had my call button. [Caregiver E] doesn't like me, I have no idea why [s/he] doesn't like me...I'm afraid of [Caregiver E] because when [s/he] handles me [s/he] handles me rough." On 06/05/2024 at 12:00 PM, Surveyor interviewed Caregiver B regarding the incident with Resident 1 on 05/24/2024. Caregiver B stated, "When I arrived, I heard [Resident 1] yelling for help and calling out staff names. [Caregiver D] and I went into [Resident 1's] room and [s/he] was on the floor near [her/his] recliner and complaining of a lot of pain. I thought [Resident 1] had a broken hip, that's why I put pillows and blankets under [her/his] hips. I asked [Caregiver D] multiple times to call someone and that it was negligence, but [Caregiver D] didn't say anything. I didn't call anyone. I should've called EMS myself even through [Caregiver D] told me not to, it was a bad mistake on both of us. I just listened to [Caregiver D] because [s/he's] older and has worked in the facility longer than me." On 06/05/2024 at 12:40 PM, Surveyor interviewed Caregiver G regarding the incident with Resident 1 on 05/24/2024. Caregiver G stated, "When I walked into the building,	N 348		

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[Caregiver B] was on the phone with EMS about [Resident 1]. I went to check on [Resident 1] and [s/he] was on the floor near [her/his] recliner with a pillow under [her/his] head. [Resident 1] said [s/he] was laying on the floor since 3 AM and [Caregiver E] ignored [her/him] throughout the night. I asked [Resident 1] if [s/he] was in pain and [s/he] said yes." Caregiver G went on to say, "I know a lot of residents reported they are scared of [Caregiver E] and so are staff."

On 06/05/2024 at 9:30 AM, Surveyor interviewed Director A regarding the incident with Resident 1 on 05/24/2024. Director A stated, "[Resident 1] told me [s/he] fell out of bed around 3 AM and laid on the floor until I came in at 8 AM. When I arrived at 8 AM, [Caregiver B] told me [Resident 1] was on the floor since [s/he] arrived at 6 AM and staff did not attempt to get [Resident 1] off the floor or call anyone. [Resident 1] said [s/he] had pain in [her/his] right hip, arm and shoulder area and requested to be sent out to the ED. I had [Caregiver B] call EMS right away. [Caregiver G] came in and gave [Resident 1] pain medication." Director A went on to say, "Nothing was done until I came in at 8 AM on 05/24/2024. I received no phone call, text, nothing. I have no idea why staff didn't call me for direction. When I started, I told staff to call me with any concerns and posted my phone number in the med room." Director A confirmed the AM staff failed to call an ambulance, contact the Regional Nurse or her/him and stated, "I would've expected staff to call me and EMS to help get a resident up off the floor."

In conclusion, Caregiver B and Caregiver D found Resident 1 on the floor in her/his room calling for help. Resident 1 alleged s/he fell out of bed at 3 AM and was ignored during the night by

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N 348	Continued From page 16 Caregiver E. When Caregiver B and D found Resident 1 on the floor at 6 AM, neither Caregiver B nor Caregiver D called the Director, Regional Nurse, or an ambulance. Consequently, Resident 1 laid on the floor until 8 AM and experienced pain in her/his right hip, shoulder/arm, and knee. 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 interviews, the provider did not ensure 1 out of 7 residents' ISPs (Individual Service Plan) was implemented as written. On 06/01/2024 during the night shift, Resident 1 was transferred with the assist of 1 staff, instead of with 2 staff and a Hoyer lift. The ISP intervention was not consistently implemented. Findings include: On 06/05/2024, Surveyor reviewed Resident 1's medical record. Resident 1 was admitted to the facility on 11/23/2023 with diagnoses to include diabetes and heart failure. Resident 1 was his/her own person and able to make her/his needs known. Resident 1's ISP dated 12/10/2023, indicated the resident required assistance with grooming, bathing, toileting, a fall	N 388		

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mat at bedside and a wheelchair for mobility. Additionally, the ISP indicated Resident 1 required a Hoyer lift for all transfers, with the assistance of two staff and noted, "[Resident 1] is not bearing much weight on legs."

On 06/05/2024 at 11:30 AM, Surveyor interviewed Resident 1 in his/her room. Resident 1 indicated s/he could not walk like s/he use to and used a wheelchair. Resident 1 then stated, "When I go to bed or need to be transferred there's just one staff here to help me. I'm supposed to be transferred with two people, but a lot of times it's just one and it's very hard for that one person to transfer me." Surveyor then asked how often s/he's transferred with one person. Resident 1 stated, "A lot."

On 06/05/2024 at 9:30 AM, Surveyor interviewed Director A regarding Resident 1. Director A indicated, Resident 1 required a Hoyer lift and two staff for a safe transfer because "[Resident 1] was dead weight and hard to transfer alone." Director A stated, "On 06/01/2024, I worked the floor by myself from 6 PM until 6 AM and I had to transfer [Resident 1] to bed by myself around 11:00-11:30 PM." Director A confirmed s/he had not followed the ISP for Resident 1 as directed. Director A then stated, "I know I'm not supposed to transfer [Resident 1] by myself but there wasn't any staff to assist me. The sister building only had one staff, and the float that was scheduled to work and help between the two buildings called in, and no one else could come in."

On 06/05/2024, Surveyor reviewed the staff schedule for the night shift on 06/01/2024. The staff schedule confirmed Director A was working alone in the building during the night shift and only one staff was working in the sister building.

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N 388	Continued From page 18 The ISP for Resident 1 was not followed as written to ensure the resident received safe transfers.	N 388		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on observation, interviews, and record review the provider did not ensure the person administering a medication or treatment documented in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record (MAR). The provider did not list oxygen as a prescribed medication/treatment or document administration of oxygen on the May or June 2024 MARs for Resident 1 and Resident 2. Findings include:	N 415		

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Resident 1

On 06/05/2024 at 11:30 AM, Surveyor interviewed Resident 1 in his/her room. Resident 1 was sitting in her/his recliner chair without the use of oxygen. Surveyor observed an oxygen machine, with the tubing and a nasal cannula resting on top of the machine, out of Resident 1's reach. Resident 1 indicated s/he wears the oxygen all the time at night and stated, "I asked staff for the oxygen earlier this morning to be put on me, but no one heard me." Surveyor located Caregiver B who assisted Resident 1 with placing the oxygen equipment on.

On 06/05/2024, Surveyor reviewed Resident 1's medical record. Resident 1 was admitted to the facility on 11/23/2023 with diagnoses to include diabetes and heart failure. Resident 1 was his/her own person and dependent on oxygen. Additionally, all of Resident 1's medications were managed and administered by staff.

On 06/05/2024 Director A provided Resident 1's MARs for May and June 2024 along with most current physician's order for oxygen. Surveyor noted the following:

-A Physician's order for Resident 1 dated 11/07/2023 prescribing oxygen 2 liters.

-Resident 1's May and June 2024 MARs did not list oxygen as a prescribed medication/treatment and there was no documentation of the dosage, date, or time the oxygen was administered.

Resident 2

On 06/05/2024 at 12:30 AM, Surveyor observed Resident 2 sitting in a recliner chair in his/her

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room. The resident was receiving oxygen through a nasal cannula via an oxygen concentrator.

On 06/05/2024, Surveyor reviewed Resident 2's medical record. Resident 2 was admitted to the facility on 09/26/2016 with diagnoses to include COPD (Chronic obstructive pulmonary disease). Resident 2 was dependent on oxygen and staff administered and managed the resident's medications.

On 06/05/2024, Director A provided Resident 2's MARs for May and June 2024 along with most current physician's order for oxygen. Surveyor noted the following:

-A Physician's order for Resident 2 signed and dated on 04/14/2021 prescribing oxygen.

-Resident 2's May and June 2024 MARs did not list oxygen as a prescribed medication/treatment and there was no documentation of the dosage, date, or time the oxygen was administered.

On 06/05/2024 at 1:00 PM, Surveyor interviewed Director A who confirmed the facility had been administering oxygen to Resident 1 and Resident 2. Surveyor shared concerns that neither the oxygen nor the administration was recorded on Resident 1's or Resident 2's MARs. Director A agreed it should be recorded on Resident 1's and Resident 2's MARs and said s/he would look into it.