STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 10/22/2024, 10/23/2024 and 10/24/2024, Surveyors conducted onsite visits to investigate 2 complaints and conduct a verification visit for Statement of Deficiency #BBRH11, dated 06/10/2024. Additional information was collected through 11/04/2024. Two (2) of 2 complaints were substantiated, 3 of 4 previous deficiencies were uncorrected and 7 new deficiencies were identified. Census: 1 Under statutory provisions of WI Stat. Ch. 50, a $200 revisit fee is being assessed.	{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.	{N 158}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 158}	Continued From page 1 This Rule is not met as evidenced by: Based on interview and record review, after receiving allegations of caregiver misconduct, the provider did not take immediate steps to ensure the safety of all residents and did not conduct or document thorough investigations within 7 days to determine if the incidents required reporting to the office of caregiver quality (OCQ). On 07/22/2024, Director A received an allegation Caregiver E neglected Resident 3. Director A did not conduct or document an investigation within 7 days to determine if neglect occurred warranting reporting of the incident to OCQ. Caregiver E continued to work as a caregiver in the facility until 10/06/2024. On 09/25/2024, Director A issued Caregiver L a written warning for neglect after Caregiver L refused to provide prompt toileting assistance to Resident 3. Director A did not document an investigation within 7 days or report the incident to OCQ. Caregiver L continued to work as a caregiver in the facility until 10/12/2024. On 10/12/2024, Director A received an allegation that Caregiver L abandoned his/her shift, knowingly leaving six residents without a dedicated caregiver in the building. Director A concluded the incident occurred as alleged but did not document an investigation within 7 days to determine if neglect occurred warranting reporting to OCQ. This is a repeat deficiency being cited for the fourth time. See Statement of Deficiency (SOD) 5MV212, dated 02/25/2021, SOD 5MV215, dated 08/16/2023 and SOD BBRH11, dated 06/10/2024.	{N 158}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 158}	Continued From page 2	{N 158}		

Findings include:

The Department received a complaint alleging concerns with the provider's response to allegations of caregiver misconduct.

Prior to conducting the onsite visit, Surveyor reviewed Department records. The provider is licensed to serve up to 16 non ambulatory residents from the following client groups: advanced age, physically disabled, irreversible dementia/Alzheimer's and traumatic brain injury. Surveyor noted the provider last submitted a misconduct incident report on 06/06/2024 for a neglect incident that occurred on 05/24/2024 involving Caregiver E.

On 10/22/2024, Surveyor observed a sister facility (building 1) is located on the same campus, across the parking lot this facility (building 1.)

Surveyor interviewed Director A on 10/22/2024 at 10:25 AM. Director A said s/he had not investigated any allegations of caregiver abuse or neglect since the neglect incident with Caregiver E on 05/24/2024. Director A stated it is his/her responsibility as the director to conduct the investigations, along with assistance from the regional office.

Surveyor reviewed the provider's Abuse and Misconduct Policy (dated 12/12/2012) on 10/24/2024 which read in part,

"It is the policy of Care Partners to assure the protection of each resident from possible abuse ...all people deserve dignified, loving care with services provided to maximize their potential for living and independence ....All employees ...are required to immediately report any known or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 158}	Continued From page 3	{N 158}		

suspected abuse to the Director ...Director will contact the Corporate Office to assist in the investigations. All reports of actual or alleged misconduct must be reported to the Department of Health Services on (misconduct incident report form) within seven (7) working days after the initial report ...DEFINITIONS ...'Abuse' means any of the following, if done intentionally. An act, omission or course of conduct by another that is not part of a treatment plan ...and does any of the following ...intimidates, humiliates, threatens, frightens, or otherwise harasses a resident ...Substantially disregards a resident's rights ...or a caregivers duties and obligations to a resident ...'Neglect' means an act, omission or course of conduct by a caregiver ...that is due to such substantial carelessness or negligence of the caregiver's duties and obligations to the resident as to create a significant danger to the physical or mental health of a resident ...."

EXAMPLE 1: CAREGIVER E - NEGLECT/VERBAL ABUSE
Director A provided Surveyor with portions of Resident 3's record on 10/24/2024, which included his/her current individual service plan (ISP) dated 07/02/2024. Resident 3 had diagnoses to include left side paralysis and anxiety. S/he was dependent on staff for assistance with toileting and transferring.

Surveyor reviewed documentation provided from Managed Care Organization (MCO), Manager A on 10/30/2024. Surveyor noted the following: 07/08/2024 - case note, "Received message from [Resident 3] (left on 07/03/2024) sent while writer was out of office. [Resident 3] states that the care provider at night is not assisting [him/her] with toileting. [S/he] feels that [s/he] being neglected...Called to Care Partners...Spoke with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 158}	Continued From page 4 [Resident 3]. [S/he] reports that [Caregiver E] comes into [his/her] room when [s/he] puts [his/her] call light on in the evening. [Resident 3] reports that [Caregiver E] turns off the call light, states that [s/he] will be right back and never returns. [Resident 3] reports that others will state the same concern." 07/22/2024 - case note, "Visit made to Care Partners met with [Resident 3]...Reports that staff member on night shift [Caregiver E] is still rude to [him/her] and is working there frequently...Spoke with [Director A]...talked about night staff [Caregiver E] and [Director A] (said s/he) does not schedule [Caregiver E] for [Building 1] anymore so doesn't understand why [Caregiver E] would be in [Building 1] at night..." Surveyor conducted a follow up interview with Director A on 10/24/2024 at 11:08 AM. Surveyor reviewed the July 2024 staff schedules with Director A. Director A confirmed the schedules documented Caregiver E was scheduled in building 1 during 3rd shift 07/01-07/03/2024 (the timeframe Resident 3 first reported concerns.) Surveyor also noted Caregiver E continued to work 3rd shift throughout the month including 8 shifts after the 07/22/2024 meeting with the MCO. Surveyor asked Director A if s/he was aware of the neglect allegations Resident 3 made during July 2024 regarding Caregiver E. Director A confirmed s/he was and stated, "...I talked with [Caregiver E] about the whole [Resident 3] situation. I said, 'We can't be arguing and turning off the call button and not checking on a resident. You have to, it's not an option. They can push 100 time and every single time you have to check on them.'" Director A also stated, "I knew there was a lot of arguments with yelling with both of them (Resident 3 and Caregiver E)...A lot of animosity	{N 158}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 158}	Continued From page 5	{N 158}		

with the two." Director A said s/he did not document the verbal warning to Caregiver E. Director A also acknowledged s/he did not take any steps other than the verbal warning to protect Resident 3 or other residents and s/he did not conduct an investigation into the incident.

EXAMPLE 2: CAREGIVER L - NEGLECT/VERBAL ABUSE
Surveyors interviewed building 2 Assistant Director K on 10/24/2024 at 12:09 PM. S/he described a staffing pattern where caregivers are primarily assigned to building 1 or building 2, but they will cover shifts in either building as needed. S/he expressed concerns about the care and treatment Caregiver L provided to the residents in building 2. S/he said, "[Caregiver L] did a lot of neglect. I don't think [s/he] did [his/her] job at all. I spoke to [him/her] about it many times." Assistant Director K said as a result of his/her concerns in building 2, Caregiver L was reassigned to primarily work in building 1.

Surveyor reviewed staff schedules August - October 2024 on 10/24/2024. Surveyors noted during August, Caregiver L was scheduled 2nd shift in building 2 but beginning in September, s/he worked 12 of 21 shifts in building 1 and in October worked 8 of 8 shifts in building 1.

On 10/24/2024 at 8:48 AM, Surveyor reviewed Caregiver L's employee record and noted documentation of the following disciplinary action: 09/25/2024 - "Employee Warning Notice...Staff being written up for refusing to take a resident to the bathroom stating [s/he - Caregiver L] was eating. Complaint from resident and staff members." The warning notice included a quote from the Abuse/Neglect policy #26 regarding neglect. Attached to the notice was a page of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 158}	Continued From page 6	{N 158}		

policy and the section defining neglect was highlighted.
The notice did not document the time of the incident, the name of the impacted resident, the staff members who witnessed/complained or the action taken by the provider to ensure future protection of all residents' health, safety and well-being.

During the aforementioned 10/24/2024 interview with Director A, Surveyor asked about the employee warning notice. Director A explained the situation again involved Resident 3. Director A said "several different staff" reported concerns about an incident when Caregiver L refused to promptly provide toileting assistance. Director A said s/he talked to Resident 3 who confirmed the incident and was "very upset with it." Director A determined Resident 3 approached Caregiver L who was in the dining room eating. Resident 3 requested toileting assistance and Caregiver L responded, "Hang on. I'm gonna [sic] finish eating." Resident 3 told Caregiver L s/he really had to go and could s/he just please take him/her to the bathroom. Caregiver L again said s/he was going to finish eating first. Director A stated, "They argued back and forth and then [Resident 3] just went in [his/her] room" and waited another 5 or 6 minutes before Caregiver L provided assistance. Director A confirmed Resident 3 needed staff assistance with toileting. Director A said his/her only documentation of the incident was the warning notice. S/he did not document the allegations, who reported them, when they were received or his/her interview with Resident 3. Director A confirmed s/he authored the warning notice for neglect, but s/he did not take any other action other than the warning notice.

EXAMPLE 3: CAREGIVER L -

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 158}	Continued From page 7 NEGLECT/ABANDONMENT Surveyor reviewed the resident roster provided by Director A on 10/22/2024. As of 10/12/2024, the facility was home to 6 residents. This included Resident 1, Resident 3 and Resident 4 and Surveyor collected information about their needs: Resident 1: Surveyor reviewed Resident 1's record on 10/24/2024 at 3:10 PM. S/he required the assistance of 2 staff for transfers and toileting and s/he tended to be awake into the late evening and early morning hours. Resident 3: As noted above, Resident 3 required staff assistance with transfers and toileting. Resident 4: Surveyor interviewed Resident 4 on 10/22/2024 at 11:39 AM and observed s/he was dependent on a wheelchair for ambulation. Resident 4 said s/he relied on the assistance of 1 staff for all transferring and toileting needs. During the aforementioned review of Caregiver L's file and the schedules, Surveyor noted the following: Employee Warning Notice dated 08/02/2024, "Staff is being written up for a no call no show. One more no call no show will result in immediate [sic] termination." August schedule - 08/20/2024 it was documented Caregiver L was a "no call" Employee Separation Statement dated 10/14/2024 read, "Staff left the facility (10/12/2024) without having proper coverage, leaving just 1 staff by [him/herself] ...No rehire." Surveyor interviewed Caregiver M on 10/22/2024 at 3:46 PM. Caregiver M recalled the following timeline of events on 10/12/2024: Caregiver L was working 2nd shift (10:00 PM - 6:00 AM) in building 1 and Caregiver M was working 6:00 PM - 6:00 AM, also in building 1. Caregiver J was working 2nd shift in building 2.	{N 158}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 158}	Continued From page 8 Caregiver J's 3rd shift relief staff in building 2 did not report. Caregiver J told Caregiver M s/he could not stay to cover 3rd shift in building 2. Caregivers M agreed to stay in building 2 and Caregiver L agreed to stay and cover 3rd shift in building 1. Caregiver L did not stay as agreed. S/he left building 1 and the six residents unattended. Caregiver M contacted Director A who told him/her to call Caregiver L and instruct him/her to come back immediately. Caregiver M texted Caregiver L and said s/he needed to come back, but Caregiver L said s/he just took his/her meds and couldn't drive. Caregiver M said s/he was left alone to cover both buildings and described it as hectic. S/he said s/he ran between the buildings at least 10 times in an effort to check the residents. Caregiver M estimated s/he was alone for approximately 4 hours until Caregiver N came in. While s/he was alone, Caregiver M said s/he had to leave building 1 unattended long enough to provide incontinence care to two residents in building 2. Caregiver M said after the incident, nobody from management interviewed him/her to ask about the details. S/he said, "It was like it didn't even come up no more [sic]. I don't know, it wasn't important enough I guess. I didn't get an interview, I had to write a statement about the incident and that was it. I gave it to [Assistant Director G]...[Assistant Director G] didn't ask any questions. I just wrote a statement and gave it to [him/her]. That's it." Surveyor interviewed Director A on 10/23/2024 at 8:33 AM. S/he confirmed awareness of the incident and showed Surveyor a text s/he received from Caregiver N on 10/13/2024 at 1:45 AM, reporting concerns a caregiver "abandoned"	{N 158}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 158}	Continued From page 9	{N 158}		

their shift. At 8:26 AM Director A replied to Caregiver N, "I am going to make calls and figure out what the [expletive] is going on. I woke up to a ton of text messages and I'm beyond confused." Director A stated to Surveyor, "[Caregiver M] should have never let [Caregiver L] leave." Surveyor asked if Caregiver M is a supervisor and Director A said s/he is not. Director A went on to say, "You can't leave one person, you can't do it."

Director A provided Surveyor with a 1 page handwritten summary dated 10/13/2024 authored by Assistant Director G. The document read in part, "When I arrived to work it was brought to my attention that 2 of the NOCs (3rd shift) didn't show up...No one called or texted me at all about this...[Caregiver M] said [s/he] didn't know that [s/he] was suppose [sic] to call me...[Caregiver L] was in [building 1] and said [s/he] was going to run to the store...and never came back..." The document did not identify how long the building was unattended, if residents were interviewed or assessed to make sure their needs were met or identify actions taken by the provider to ensure future protection of the residents' health, safety and well being.

Director A confirmed Assistant Director G's summary was the only documentation completed in response to the incident and said s/he (Director A) did not conduct an investigation. Surveyor asked if s/he knew how long there was only 1 staff for the 2 buildings and s/he did not know. While in the office with Surveyor, Director A looked at timesheet records and said Caregiver J punched out at 10:15 PM, Caregiver L punched out at 10:30 PM and relief staff Caregiver N punched in at 11:45 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 158}	Continued From page 10 The "WISCONSIN BACKGROUND CHECK AND MISCONDUCT INVESTIGATION PROGRAM MANUAL" last updated 10/2024, is published by DHS and serves as a resource for providers. It reads in part, "All entities regulated by DQA must conduct a thorough internal investigation and document the findings for all allegations or incidents at the entity. A thorough internal investigation may include: Collecting and preserving any physical and documentary evidence...Interviewing alleged victims and witnesses; Collecting other corroborating/disproving evidence; Involving other regulatory authorities who can assist (e.g., local law enforcement, elder abuse agency, Adult Protective Service agency, DQA, Board on Aging Ombudsmen,Client Right ' s Specialist, etc.); and Documenting each step taken during the internal investigation. These steps should be taken as part of the entity's initial attempt to determine what, if anything, happened and to determine the complete factual circumstances surrounding the alleged incident. An entity's internal investigation will assist in determining if an incident must be reported to DQA...Protection of Clients - Immediately upon learning of the incident, the entity must take necessary steps to protect clients from possible subsequent incidents of misconduct or injury...Entity Internal Investigative Report - The entity must investigate any allegation, incident, or suspected occurrence of misconduct. A timely and thorough entity investigative report is required. An internal investigative report provides: A record of the entity's internal investigator's activities and findings so that nothing is left to memory. A permanent official record of the entity's internal investigator's actions, observations, and discoveries A basic reference of the case. Information on what has been done concerning	{N 158}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 158}	Continued From page 11 the case. A basis for deciding further action. A method to communicate the findings of the case..." Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations	{N 158}		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on interview and record review, Licensee N did not ensure the CBRF and its operation comply with all laws governing the CBRF. The is a repeat deficiency being cited for at least the third time. See Statement of Deficiency (SOD) 5MV214, dated 09/01/2022, SOD 5MV213, dated 06/30/2021 and SOD BBRH11, dated 06/10/2024. Findings include: As result of quality of service concerns, MCO S terminated their contract with the provider and relocated their residents. On 10/30/2024 at 3:30 PM, MCO S emailed Surveyor the notice dated 09/10/2024 which read in part, "Dear [Licensee N]: [MCO S] is sending this notification to advise you that the subcontract agreement between	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 196	Continued From page 12 [MCO S] and Care Partners Assisted Living-Stevens Point (building 1) will be terminated as of 10/10/2024. This termination is...a for cause for termination due to deficiencies in quality of service. [MCO S] will be working with you to move members out of the facilities within the next 30 days." At the time the notice was issued, 6 of 7 residents received services from MCO S. As of 10/22/2024 when Surveyor conducted the onsite visit, all 6 residents has been relocated and the census was 1. On 10/22/2024, Director A provided Surveyor a copy of an involuntary discharge notice that was issued to the remaining resident on 10/15/2024. The notice was signed by Licensee N was not based on reasons permitted by the code. During the past 4 years the provider has displayed a pattern of ongoing non-compliance with regulations. The current survey BBRH12, dated 11/04/2024 - 2 of 2 complaints substantiated, 4 of 5 uncorrected deficiencies, 7 new deficiencies with 5 being repeat deficiencies Caregiver: Investigating Abuse & Neglect- third recite and uncorrected from BBRH11. Licensee Ensures Facility Complies with Laws - recite Allowable Reasons for Involuntary Discharge Implement, Follow The Individual Service Plan - recite and uncorrected from BBRH11 Service Plans Updated Annually Or On Upon Changes - recite Documentation of Medication Administration - recite and uncorrected from BBRH11 On 10/30/2024 at 10:00 AM, Surveyor conducted an exit conference with Licensee N and other	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 196	Continued From page 13	N 196		

management staff. Surveyor reviewed plan of correction (POC) documentation, provided by Director A during the onsite visit on 10/24/2024. Licensee N said s/he was not familiar with the documentation and was not involved in the development of the POC.

The current survey is at least the 6th consecutive survey with substantiated complaints, uncorrected deficiencies and/or repeat deficiencies.

SURVEY EVENT HISTORY:

SOD 5MV211, dated 06/25/2000 - 1 of 5 complaints substantiated and 2 deficiencies:
Supervision - related to the elopement of a resident who left the facility twice within four days.
Health Monitoring - related to a resident who suffered a change of condition, which was not assessed or reported. The resident went to the hospital the next day and later died of urinary sepsis.

SOD 5MV212, dated 02/25/2021 - 2 of 2 complaints substantiated, 1 of 2 deficiencies uncorrected and 9 new deficiencies.
Caregiver: Investigating Abuse & Neglect - related to an allegation of caregiver abuse and an incident of caregiver neglect. Neither incident prompted the provider to take immediate steps to protect residents, or complete a thorough investigation of the incidents.
Orientation
All Employee Training
Rights Of Residents: Receive Medication - related to the administration of medications to a diabetic resident.
Service Plans Updated Annually Or On Changes
Qualified Staff In Charge, On Duty and Awake

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 196	Continued From page 14 Health Monitoring Infection Control Program Care Special order: "the Department of Health Services HEREBY ORDERS that Care Partners Stevens Point 1 NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations in Statement of Deficiency (SOD) #5MV212 are corrected...Pursuant to Wis. Stat. § 50.03(5g)(b)6....the licensee shall ensure the administrator supervises the daily operation and ensures the provision of services to meet residents' physical and mental health needs. In consultation with a Registered Nurse (RN), the licensee will develop (or review/revise) procedures to address...Health Monitoring...Caregiver Misconduct..." SOD 5MV213, dated 06/30/2021 - 1 of 9 deficiencies uncorrected, 3 new deficiencies with 2 of 3 being repeat deficiencies. Licensee Ensures Facility Complies with Laws Infection Control Program Interior Floors, Walls and Ceilings SOD 5MV214, dated 09/01/2022 - 1 of 3 complaints substantiated, 2 of 3 deficiencies uncorrected, 4 new deficiencies with 2 of 4 being repeat deficiencies. Licensee Ensures Facility Complies with Laws Rights Of Residents: Confidentiality Medication Storage: Locked Cabinet Infection Control Program SOD 5MV215, dated 08/16/2023 - 1 of 1 complaint substantiated, 8 new deficiencies with 3 of 8 being repeat deficiencies. Caregiver: Investigating Abuse & Neglect Investigate Injuries of Unknown Source Orientation Continuing Education	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 196	Continued From page 15 Rights Of Residents: Free From Mistreatment Leisure Time Activities Rooms Clean and Free From Odors Interior Floors, Walls and Ceilings Special order: "Pursuant to Wis. Stat. § 50.03(5g)(b)6., the licensee shall develop and implement corrective measures to ensure the provision of a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents." SOD 5MV216, dated 03/14/2024 - Department orders for revocation and no new admission; pending appeal. SOD BBRH11, dated 06/10/2024 - 1 of 1 complaint substantiated, 4 new deficiencies with 2 of 4 being repeat deficiencies. Caregiver: Investigating Abuse & Neglect Rights Of Residents: Free From Mistreatment Implement, Follow The Individual Service Plan Documentation of Medication Administration Special order dated 07/01/2024: "EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services hereby extends the order issued on June 7, 2024, with Statement of Deficiency (SOD) 5MV216, that Care Partners Stevens Point 1 Not Admit any New or Additional Residents...Pursuant to Wis. Stat. § 50.03(5g)(b)3., effective immediately, the licensee shall comply with the requirements specified by Wis. Stat. ch. 50 and Wis. Admin. Code ch. DHS 83 that establish the standards for the operation of the Community Based Residential Facility in order to protect and promote the health, safety and welfare of the residents."	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 196	Continued From page 16 Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0327 DHS 83.31(4)(b) Allowable Reasons For Involuntary Discharge N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0415 DHS 83.37(2)(d) Documentation of Medication Administration	N 196		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on observation, interview and record review, Administrator H did not supervise the daily operations of the CBRF to ensure residents received necessary care and services, their rights were protected and they lived in a safe environment.	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 214	Continued From page 17 Administrator H did not oversee the day to day operations to ensure all deficiencies from the previous survey were corrected, resident rights were respected and staff disciplinary matters were monitored to ensure appropriate care and treatment of residents. Findings include: DAILY OPERATIONS On 10/22/2024 beginning at 9:10 AM, Surveyors conducted the first of 3 consecutive facility visits. Director A was present and was subsequently joined at approximately 10:30 AM by Regional Manager P. Surveyors informed the managers there was significant survey work to conduct including the investigation of 2 complaints and a verification visit for 4 the deficiencies identified in SOD BBRH11, dated 06/10/2024. Administrator H did not arrive onsite during the visit on 10/22/2024. On 10/23/2024 Surveyors returned and spent most of the day in the facility. Administrator A was not present. At 9:40 am, Surveyor asked Regional Manager P when Administrator H was last onsite. S/he replied, "[S/he] was just here a week ago or 2 weeks ago" and said Administrator H is usually is in the facility 2 or 3 times a month. Regional Manager P said, " [S/he] looks at the medication carts each time and the medication administration records...[Administrator H] had a scheduled visit here yesterday, then with you here that got postponed." Surveyor asked why Surveyor's presence would postpone the visit and Regional Manager P said, "We thought it would be busy." At the conclusion of the 2nd day, Surveyor informed Director A s/he would be returning the following morning.	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 214	Continued From page 18 On 10/24/2024, Surveyor arrived at 8:08 AM. Director A was present but neither Regional Manager P nor Administrator H were onsite. At 9:31 AM, Surveyor reviewed Director A's employee record. On his/her employment application for a secretarial position dated 02/01/2021 s/he wrote, "currently getting my GED." Director A's record did not contain evidence of completion of the administrator course, an associate or bachelor's degree or a nursing home administrator license. It did not contain evidence s/he was a registered nurse (RN.) On 10/24/2024 during an interview beginning at 11:08 AM, Director A said Regional Manager P informed him/her via text earlier in the morning s/he would not be coming but s/he did not have information about why. Surveyor asked if Administrator H was informed Surveyors would be returning for a 3rd day and Director A confirmed s/he was. Director A was emotional during the interview and acknowledged feeling overwhelmed. S/he stated s/he has been responsible for the day to day operations of the facility and was doing the best s/he could. Surveyor asked if s/he had completed the administrator course or was a RN, and s/he said s/he was not. STAFFING CONCERNS: Resident 1: Prior to the onsite visit, Surveyor reviewed the deficiencies from the previous survey (SOD BBRH11, dated 06/10/2024.) A deficiency was identified due to the provider not ensuring Resident 1 was free from neglect. On 05/24/2024 upon arrival for the AM shift, 2 caregivers found Resident 1 on the floor in her/his room calling for help. Resident 1 alleged s/he fell	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 214	Continued From page 19 out of bed at 3 AM, was calling for help throughout the night and Caregiver E ignored her/his cries. Surveyor interviewed Resident 1 on 10/30/2024 at 2:20 PM. Resident 1 said s/he just recently moved to a new facility. Resident 1 expressed concerns about Caregiver E during his/her time living at Care Partners. S/he stated, "[Caregiver E] didn't like me for some reason. I don't know why, but [s/he] didn't...people would ask me if [s/he] was still working there and I'd say 'Yeah.' Sounded like [s/he] should have been gone, but [s/he] was there...I tried to keep [him/her] from doing anything for me. I was scared of [him/her]. I'm not a scared person about a lot of things, but I really was. I'm helpless now. I can't do nothing for myself. When [s/he] was working I would sometimes call for help. Sometimes [s/he]'d come, sometimes [s/he] wouldn't." Resident 1 said sometimes s/he wouldn't call at all for help and try to transfer him/herself, which occasionally lead to falls. On 10/24/2024 at 9:00 AM, Surveyor reviewed Caregiver E's employee file and staff schedules and noted the following: 05/24/2024 - "Employee Warning Notice" authored by Director A read, "[Caregiver E] did not follow Care Partners policy...when a resident had a fall out of bed which resulted in resident rights being violated to receive promted [sic] and adequate treatment to the resident needs." [sic - all] Caregiver E signed the notice more than 2 months later on 07/31/2024. Caregiver E remained on the schedule working 3rd shift 18 times during July and 1 time during August (on 08/15.) The rest of August Caregiver E was on the schedule for building 2, the sister facility.	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 214	Continued From page 20 08/26/2024 - "Person Improvement Plan" (PIP) identified goals to stay off his/her phone, maintain a positive attitude with residents, stay in facility and do not leave it unattended, do not sit and watch TV and "update director/assistant directors as to what was completed by you on your shift at the end of your shift via text." The plan read, "This is a 30 day improvement plan, if these things are not followed on and not improved then that will cause for immediate termination." [sic - all] signed by Director A Caregiver E remained on the schedule for building 1 working 7 times during September and 2 times during October 2024. 10/07/2024 - "Employee Separation Statement" due to "Not following corrective plan, work ethic, time management, Innappropriate [sic] conduct." Last day worked was 10/06/2024. Signed by Director A. Surveyor reviewed Resident 1's records on 10/23/2024 at 3:10 PM. Resident 1 was non-ambulatory and relied on the assistance of 2 staff for transfers using a Hoyer lift, toileting, incontinence care and other activities of daily living. Resident 1 was his/her own legal decision maker and resided at the facility until 10/17/2024. Resident 1 sustained falls on 07/05/2024 at 2:27 AM and 08/04/2024 at 6:00 PM and both fall reports were authored by Caregiver E. According to staff schedules, on 07/05 and 08/04 Caregiver E was only 1 of 2 caregivers scheduled for both buildings, indicating s/he was working alone in building 1. Resident 1's record also contained observation notes authored by Caregiver E on 08/01, 08/02, 08/15, 08/19 and 08/21, indicating Caregiver E was working in building 1 more often than the schedule reflected.	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 214	Continued From page 21 Resident 2: Surveyor also received and reviewed records from Managed Care Organization (MCO) Manager I on 10/30/2024 at 10:21 AM. Case notes documented concerns with Caregiver E and Resident 2 during July 2024: On 07/03 and 07/08 Resident 2 reported to the MCO team that Caregiver E was neglecting him/her because s/he was not assisting him/her at night with toileting. Resident 2 stated sometimes s/he would clear the call light, say s/he would return, but then not return. On 07/22 Resident 2 reported to the MCO team Caregiver was still "rude to [him/her]" and was still working there frequently. The case worker noted, "Spoke with [Director A]...talked about night staff [Caregiver E] and [s/he] does not schedule [Caregiver E] for [building 1] anymore so uncertain why [Caregiver E] would be in [his/her] building at night." On 07/29 MCO internal note: "discussion with [MCO Staff R] ...regarding caregiver who [Resident 2] has concerns with. [Staff R] reports that [s/he] did observe that caregiver interacting with [Resident 2] when [s/he] was visiting the CBRF. [Staff R] reports that the caregiver appeared rude ...will visit [Resident 2] for 60 day visit and will go later in the day when this caregiver is typically working. Informed [Staff R] that CBRF director (stated) ...this caregiver works in the other building. [MCO Staff R] reports that the caregiver was working in [Resident 2]'s building." Staff Interviews: Surveyor interviewed building 2 Assistant Director K on 10/22/2024 at 12:09 PM. S/he said Caregiver E worked in both building 1 and building 2, and during the past 2 months there were times Caregiver E worked alone in building 1. S/he expressed concerns about Caregiver E's	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 214	Continued From page 22	N 214		

care and treatment of residents in both buildings and said s/he reported concerns frequently to Director A. S/he stated, "[Resident 1 and Resident 2] didn't like [Caregiver E]...they would make statements 'Why do all the nice staff work in building 2?'" Assistant Director K said when s/he covered shifts in building 1, the residents would complain Caregiver E wouldn't answer their call lights or provide care. Assistant Director K also described Caregiver E as being "rude" towards residents.

Surveyor interviewed Director A on 10/24/2024 at 9:02 AM. S/he confirmed Caregiver E was placed on a PIP on 08/26/2024, but his/her performance and communication did not improve so s/he was terminated on 10/07/2024. Director A said there was no additional documentation in connection with the PIP or monitoring of Caregiver E's work performance between 08/26 and 10/07/2024.

Surveyor interviewed Administrator H and Regional Manager P on 10/30/2024 at 10:00 AM. Administrator H explained s/he is a regional nurse for "11 or 12 different sites, about 15 different buildings" within the organization. Administrator H stated s/he was unfamiliar with the circumstance of the 05/24/2024 neglect incident involving Caregiver E and Resident 1, as identified in the previous survey. Administrator H said s/he was unaware of Caregiver E's PIP or eventual termination. Additionally, s/he said oversight of appropriate scheduling and of staff disciplinary matters are the responsibility of the facility director.

During the interview, Surveyor reviewed concerns that Caregiver E was written up on 05/24/2024 for not providing appropriate care to Resident 1 and then new neglect concerns were raised by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 214	Continued From page 23	N 214		

MCO on Resident 2's behalf during July 2024. Yet, Caregiver E remained on the schedule responsible for both residents' cares during 3rd shift, and at times was working alone in the building. Administrator H did not provide additional information in response Surveyor's summary of the concerns.

RESIDENT RIGHTS/CARE CONCERNS:
Smoking Restriction: During the aforementioned review of Resident 1's record, Surveyor noted the following observation notes:
10/01/2024 - 3rd shift, "Resident was in room when I arrived. I went to check on [him/her] ...and [his/her] room smelt [sic] like cigarettes ...[S/he] admitted to bringing the butts inside but did not admit to smoking. On 9/30 I smelt [sic] smoke as well but not as potent. I mentioned to coworkers to not allow lighters in [his/her] room ..."
10/03/2024 - "Director talked with resident about [his/her] smoking privalige [sic] is taken away due to being caught smoking in room on several occasions and multiple conversations about it. Director printed smoking policy ...to have Resident sign." Author: Director A

On 10/23/2024 at 3:40 PM, Surveyor interviewed Director A who confirmed it was his/her decision to take away the "privilege." [S/he] said Resident 1 was "OK with it. [S/he] understood it was a very big safety concern." Director A said prior to the restriction, the cigarettes had been kept in the locked medication cart so caregivers had an awareness of when Resident 1 was smoking. S/he said Resident 1 also received warnings about smoking in his/her room. Surveyor asked if the provider considered less restrictive options, like supervising Resident 1 while s/he smoked to ensure s/he would not bring the smoking materials back to his/her room. Director A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 214	Continued From page 24	N 214		

acknowledged the lesser restrictive option of supervision was not attempted.

During the aforementioned interview with Resident 1 s/he said, "They took my cigarettes because they said they caught me smoking but I wasn't smoking." Resident 1 said for the last 3 weeks s/he resided at the facility s/he was not allowed to smoke. Surveyor asked if s/he was okay with the decision and s/he replied, "No I wasn't. But you do what you have to do."

During an interview with Caregiver Q on 10/30/2024 at 3:03 PM s/he confirmed Director A "revoked" Resident 1's smoking "privileges." Caregiver Q said staff were not expected to supervise Resident 1 outside while s/he smoked. Caregiver Q said for a while Resident 1 wasn't smoking in his/her room but once hospice implemented the use of chair alarms, Resident 1 didn't want to transfer and risk sounding the alarm. Caregiver Q said it was his/her impression that is why Resident 1 started bringing the smoking materials into his/her room instead of going outside.

Plan of Correction Documentation: On 10/24/2024 at 8:10 AM, Director A provided Surveyor a plan of correction binder (POC). The binder included a copy of SOD BBRH11, dated 06/10/2024.

A section of the binder included documentation of training, including training that occurred during staff meetings. Examples include:

A meeting on 08/15/2024 documented a 3 hour training on resident rights provided by an outside agency. However, the meeting notes concurrently identified ongoing resident care and resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 214	Continued From page 25 rights concerns. "Residents are being ignored and complaining because you guys are on your phones way to much." "Medications that are not being given is absolutely not ohkay [sic] at all. You need to be on top of it. If there continues to be issues with meds...you will be pulled from the med cart and I will have the regional nurse do redelgations [sic] with you." "Residents are not getting changed or checked on like they are supposed to be, they NEED to be changed and checked every 2 hours if not more!" "MEAL TIMES, breakfast goes from 8am to 9am, lunch goes from 12pm to 1pm, and dinner goes from 5pm to 6pm. No making full meals for residents after meal times. If they are hungry and want something make them a sandwich or offer a snack. Kitchen closes at 10pm, nothing goes out after 10pm unless the resident is providing their own food. We are required to provide 3 meals a day and snacks. Not as many meals as they want our budget is not big enough for that...." "Residents cannot be eating in their rooms, we are getting new carpet and with the eating and drinking juice or soda in their rooms and then it getting spilt [sic] is going to ruin the new carpet! If they want a drink in their room then they can have water in their rooms. They are allowed to have food but if they are wanting to eat it then they need to come out to the dining room." "Staff need to stop going outside all together, that is leaving the building unattended and that is a big issue as we do have fall risk and choke risk residents in the building." "Absolutely NO using ANY type of drugs at work!! Maintenance found some ones [sic] pipe" Staff meeting on 09/19 "Boundaries! Staying busy during your entire shift,	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 214	Continued From page 26 stop slacking! Staff can be put in either building; easy on food." Undated meeting notes authored by Assistant Director G: "Respect boundaries! Personal life stays out of work!" "I can put whoever in either building, it is ultametly [sic] my choice who work [sic] where." "If I keep getting complaints about staff consistantly [sic] sitting during shift and not doing job duties, you will be written up and days will be taken away." "Be easy on the food! You do not pay for it and we only have 6 residents per building!" During the aforementioned interview with Administrator H and Regional Manager P, Surveyor reviewed some excerpts from the 08/15/2024 staff meeting identifying care concerns and rights restrictions. Regional Manager P said s/he re-educated staff at a director's meeting about the rights restrictions with closing the kitchen at 10:00 PM and prohibiting food/drink in their rooms. Surveyor requested documentation to show direct care staff were also re-educated. On 10/30/2024 at 3:30 PM, Regional Manager P sent an email indicating s/he asked Director A if s/he "provided reeducation to [his/her] staff about residents' rights surrounding meal times and eating in their rooms. [S/he] stated that [sic] provided verbal reeducation to [his/her] staff members after our regional meeting on 9/4/2024." During the aforementioned interview with Resident 1, s/he said, "I couldn't eat in my room. I don't know why, they used to (let us), but then they stopped we couldn't eat in our room at Care Partners anymore...I had to eat in the dining	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 214	Continued From page 27 room. Here (at the new facility), I can eat in my room." During the aforementioned review of Resident 1's records, Surveyor noted in order for Resident 1 to be able to eat outside of mealtimes, s/he would need to be transferred via a Hoyer lift to his/her wheelchair and brought to the dining room. Surveyor also reviewed an observation note authored by Caregiver E on 08/21/2024, "Resident pushed button constantly throughout the night for food." The note did not indicate whether Resident 1 was provided the food. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0327 DHS 83.31(4)(b) Allowable Reasons For Involuntary Discharge N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0415 DHS 83.37(2)(d) Documentation of Medication Administration	N 214		
N 327	83.31(4)(b) Allowable reasons for involuntary discharge. Discharge or transfer initiated by CBRF. Reasons for involuntary discharge. The CBRF may not involuntarily discharge a resident except for any of the following reasons: 1. Nonpayment of charges, following reasonable opportunity to pay. 2. Care is required that is beyond the CBRF ' s license classification. 3. Care is required that is inconsistent with the CBRF ' s program statement and beyond that which the CBRF is required to provide under the terms of the admission	N 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 327	Continued From page 28 agreement and this chapter. 4. Medical care is required that the CBRF cannot provide. 5. There is imminent risk of serious harm to the health or safety of the resident, other residents or employees, as documented in the resident ' s record. 6. As provided under s. 50.03 (5m), Stats. 7. As otherwise permitted by law. This Rule is not met as evidenced by: Based on record review and interview, on 10/14/2024 the provider initiated the discharge of Resident 4 for reasons inconsistent with the reasons permitted by the code. Findings include: Surveyor interviewed Director A on 10/22/2024 at 10:45 AM. S/he explained in the past week all residents but 1 had moved out and the remaining resident, Resident 4, had been issued a discharge notice. Director A said s/he was not involved in the decision to discharge but according to letter provided by the corporate office, the reason for discharge was "restructuring." Regional Manager P subsequently joined the interview and stated the discharge notice was "due to staffing levels and going forward with restructuring and we are unable to provide cares...We are looking at major renovations and things and [Licensee N] is deciding next steps for the 2 facilities...The thirty-day notices were given at [Licensee N]'s directive." Director A provided Surveyor a copy of Resident 4's notice during the interview. It was dated	N 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 327	Continued From page 29 10/15/2024, addressed only to MCO Representative O and read in part, "We regret to inform you that at this time (we)...must issue a thirty-day notice to [Resident 4]. Care Partners Stevens Point will be undergoing restructuring and we feel we have no choice but to issue this thirty-day notice. [Resident 4]'s last day of residency...will be November 13, 2024. By this date, please have all [Resident 4]'s belongings removed from the facility. We will do everything we can to help with locating a new residency [sic]..." The letter was signed by Licensee N. Surveyor interviewed Resident 4 on 10/22/2024 at 11:39 AM. Resident 4 volunteered, "They're going to close. I'm moving out in a week or two." Resident 4 said the reason for closure was, "Something about restructuring. I got a letter, I can show you." Resident 4 provided Surveyor with the same letter dated 10/15/2024 Director A had provided to Surveyor. It was only addressed to the MCO informing them Resident 4 would need to move out by 11/13/2024. Resident 4 stated s/he is his/her own legal decision maker. On 10/25/2024 at 10:10 AM, Director A emailed Surveyor and wrote, "Hello, These are the 30 day notices that were issued reissued [sic] to the families, was giving these to you to make sure that you had these for you file. Thank you." Attached to the email was a different version of the notice. It was dated 10/17/2024 and still only addressed to MCO O. The reason for discharge and last day of residency had changed. The notice read in part, "Due to the staffing shortages we are experiencing we feel we cannot adequately meet the medical needs of this resident. We feel we have no choice but to issue this thirty-day notice. Care Partners does have other facilities that are fully staffed that would be	N 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 327	Continued From page 30	N 327		

able to transfer [Resident 4] if you would choose to. [Resident 4]'s last day of residency...will be November 15, 2024. By this date, please have all [Resident 4]'s belongings removed from the facility..." The letter was signed by Licensee N.

On 10/30/2024 at 10:00 AM, Surveyor conducted an interview with Licensee N and Regional Manager P. Licensee N confirmed the discharge notices were issued and stated, "We have staff that are leaving the operation because they are down to...1 resident and we don't know what the future of the building holds with the no new admission order, so long-term I don't know we would be able to meet the needs of the residents." (Surveyor note: the provider is currently under special orders from the Department not to admit new residents due to the survey findings in 5MV216, dated 04/14/2024 and SOD BBRH11, dated 06/10/2024.)

During the interview, Surveyor informed Licensee N and Regional Manager P the reasons for discharge were not consistent with the reasons permitted in DHS 83.31. Regional Manager P responded, "One of the reasons to give notice is failure to meet residents needs and we are stating that we are failing to meet (the resident's) needs." Surveyor again reviewed the permitted reasons for discharge, along with the requirement of DHS 83.36(1)(a) to provide sufficient staff to meet the needs of the residents. Neither Licensee N nor Regional Manager P provided additional information as evidence the involuntary discharge notice was issued based on one of the permitted reasons in DHS 83.31.

Cross Reference:
N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 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 ensure Resident 1's ISP intervention for 2 staff to assist with all transfers was consistently implemented. This is a repeat deficiency. See SOD BBRH11, dated 06/10/2024. Findings include: Surveyor reviewed Resident 1's facility record on 10/23/2024 at 3:10 PM. Resident 1 was admitted to the facility in November 2023 with diagnoses to include diabetes, heart failure, chronic pain, anxiety and depression. The most current ISP signed and dated 07/02/2024 read in part, "is able to make needs and wants known effectively with staff and other peers...does have weakness from a stroke...Has chronic pain, shortness of breath, and is a 2 assist with all transfers in the hoyer ...likes to sleep in but then is up all night...is incontinent of urine and bowel...is a 2 assist with toileting...is a 2 assist with changing." Resident 1 was his/her own legal decision maker and discharged from the facility on 10/17/2024. Surveyors interviewed Director A on 10/22/2024 at 10:25 AM and 10/24/2024 at 8:33 AM. Director A said the minimum staffing pattern was 1 staff in this building (building 1), 1 staff in the sister facility located across the parking lot (building 2) and a caregiver scheduled as a "float" to help in either building. Director A said that had been the	{N 388}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 388}	Continued From page 32	{N 388}		

minimum amount of staff necessary since July 2024 and up until the prior week when all but 1 resident moved out. Director A said staffing had been "very steady" especially during August and September and s/he hadn't needed to work as a caregiver during those months to fill in vacant shifts. Surveyor asked if there always was a float working and Director A replied, "We always had to have the extra person because over here (in building 1) there is a 2 assist." Director A clarified Resident 1 is the resident who needed the assistance of two staff for all transfers.

Surveyor reviewed the September 2024 scheduled and noted times when there was not a float scheduled. Examples include (but are not limited to):
Saturday 09/07: no float between 6:00 AM and 10:00 PM
Sunday 09/08: no float between 7:00 PM and 10:00 PM
Saturday 09/21: no float between 6:00 AM and 6:00 PM or between 10:00 PM - 12:00 AM
Sunday 09/22: no float between 12:00 AM and 2:00 PM or between 2:30 PM and 6:00 PM
During 3 of the 4 aforementioned timeframes, Caregiver Q was on the schedule.

Surveyor conducted a follow up interview with Director A on 10/24/2024 at 11:08 AM and reviewed the September schedule and concerns that the previously identified minimum staffing pattern was not consistently maintained. Director A confirmed Surveyor's review of the schedule for the 2 weekends, which documented there was only 1 caregiver in each building and no caregiver as a float. Surveyor asked if s/he had additional information to provide about staffing levels on those dates and s/he said s/he did not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 388}	Continued From page 33 Surveyor interviewed Caregiver Q on 10/30/2024 at 3:03 PM. Caregiver Q said sometimes a float caregiver was not scheduled and when that happened, "I would have to transfer (Resident 1) alone." Caregiver Q also said when s/he was alone sometimes s/he would use the Hoyer, but other times s/he would not. S/he explained during July and August, Resident 1's Hoyer lift "wasn't the best one...it was digging into [his/her] legs" and was difficult for staff to use. Once the new one arrived in early September, Resident 1 was more receptive. Surveyor interviewed Resident 1 on 10/30/2024 at 2:20 PM. Resident 1 said when s/he lived at Care Partners most of the time only 1 staff would help him/her with transfers and they wouldn't use a lift. S/he said caregivers would "normally pick me up and move me." Surveyor conducted an interview with Administrator H and Regional Manager P on 10/30/2024 at 10:00 AM. Administrator H said it is the director's responsibility to ensure adequate staff to meet resident needs and s/he was unaware of any times Director A did not ensure there were at least 2 staff available to provide transferring assistance to Resident 1. Surveyor reviewed the concerns a float/second caregiver was not always available to implement Resident 2's ISP intervention for 2 staff to assist with transfers. Surveyor reviewed the 4 dates in September as examples when the schedule documented only one caregiver was in the building. Regional Manager P responded, "Are you including [Director A] being there as being a float?" Surveyor informed Manager P s/he interviewed Director A about the dates in question and the schedule and Director A did not state s/he worked any of the 4 dates. Surveyor informed	{N 388}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 388}	Continued From page 34 Regional Manager P if s/he determined Director A worked any of those 4 shifts to provide documentation of timesheet records by the end of the day. At 4:24 PM, Regional Manager P sent Surveyor an email that read in part, "I spoke with [Director A] regarding the short staffing on September 7, 8, 21, and 22. [S/he] stated [s/he] worked 9/7/24 and 9/8/24 due to a no call no show. [S/he] did not work 9/21/24 and 9/22/24. [S/he] took your questioning to be asking which of [his/her] caregivers were scheduled that day, not to include [him/herself]." The email included a written statement from Director A stating s/he worked 7:00 AM - 3:00 PM on 09/07 and 09/08. Surveyor responded to the email and requested timesheet documentation to verify Director A's statement, as well as any timesheet documentation for any other dates s/he worked as a caregiver August - October that were not accurately documented on the schedule. Regional Manager P did not respond to the email. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan	{N 388}		
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	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 389	Continued From page 35 on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's individual service plan (ISP) was updated based on assessment to meet his/her needs for fall prevention. Between 07/05 - 09/15/2024, Resident 1 experienced 5 times where s/he was found on the ground after apparent attempts to self-transfer and on 10/15/2024 a fall risk assessment documented an increase in his/her fall risk. Resident 1's ISP dated 07/02/204, was not updated to identify interventions to mitigate his/her risk of falls. This is a repeat deficiency. See Statement of Deficiency 5MV212, dated 02/25/2021. Findings include: Surveyor reviewed Resident 1's complete record on 10/23/2024 at 3:10 PM. Resident 1 was admitted to the facility in November 2023 with diagnoses to include diabetes, heart failure, chronic pain, anxiety and depression. The most current ISP signed and dated 07/02/2024 by Resident 1, Director A and funding source staff	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 389	Continued From page 36 read in part, "...does have weakness from a stroke...is a 2 assist with all transfers in the hoyer...has a history of refusing the hoyer and will try to self transfer which causes [him/her] to fall...Has a fall mat that is to be used when [s/he] is in bed ...is a fall risk de [sic] to self transferring and weakness." The ISP noted, "hospice as of 08/27/2024." Resident 1 was his/her own legal decision maker and discharged from the facility on 10/17/2024. Surveyor noted: The ISP did not identify interventions based on assessment, to mitigate the fall risk associated with self-transferring. The only update to the ISP after 07/02/2024 was the note about hospice on 08/27/2024. Surveyor noted after the 07/02/2024 ISP, there were 5 times when Resident 1 was found on the ground after apparent attempts to self-transfer. Fall reports 07/05 2:27 AM (date/time of incident) - "tried to self transfer and had fall" [sic] - Author: Caregiver E 07/24 4:20 PM - "attempting to self transfer from wheelchair to the chair. Said [s/he] got tired and lower to the ground." [sic] 08/04 6:35 PM - "found on the ground yelling for help" - Author: Caregiver E - Director follow up & comments: "Make sure resident knows to call for help. Sign posted 'call don't fall'" 09/06 2:35 PM - "yelling for help. Staff went in there. Resident was sitting on the floor ....asked what happened [s/he] said [s/he] was self transferring ...slipped." 09/15 2:32 PM - "tried to self transfer out of [his/her] recliner. Went down like [s/he] slid out of[his/her]chair."	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 389	Continued From page 37 The record contained a fall assessment document. The document prompted for numeric scores in areas to include mental status, history of falling, ambulation and transfer safety. The form did not include prompts for root cause analysis of the falls or prompts for possible interventions. The form read, "Score of 9 or above indicates risk of falling." Assessments and scores were documented 3 times during 2024. There was a increase in Resident 1's fall risk score between June 2024 and October 2024: 02/15: score 15 06/10: score 15 10/04: score 24 (signed by Director A) Surveyor interviewed Resident 1 on 10/30/2024 at 2:20 PM. Resident 1 said s/he needed help with transfers, but sometimes s/he would call for help and staff wouldn't respond. Resident 1 said other times s/he would choose not to call for help, especially when Caregiver E was working. Resident 1 said, "S/he didn't like me for some reason..." Surveyor interviewed Caregiver Q on 10/30/2024 at 3:03 PM. Caregiver Q said Resident 1 didn't like the old Hoyer lift because "it wasn't the best one." S/he said it dug into Resident 1's legs and was difficult for caregivers to use. Caregiver Q said about 2 months ago Resident 1 got a different lift which "worked better" and Resident 1 was more receptive to using it. Caregiver Q also said hospice implemented use of a chair alarm to alert staff when Resident 1 tried to self-transfer. Surveyor interviewed Director A on 10/23/2024 at 3:40 PM, 4:14 PM and 4:20 PM. S/he stated the following: Director A developed the ISP dated 07/02/2024 it	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 389	Continued From page 38 was the current ISP in effect from 07/02/2024 until Resident 1 moved out. Resident 1 was at risk for falls, in part due to the tendency to self-transfer. The ISP did not include interventions based on assessment to mitigate Resident 1's tendency to self-transfer and the associated fall risk. Caregiver E had been disciplined in the past for not providing care to Resident 1 and in hindsight it may have contributed to Resident 1's reluctance to call for help when Caregiver E was working. When residents are admitted to hospice, the provider maintains their own ISP which incorporates the hospice plan of care. Resident 1's record did not include the hospice plan of care, visit notes or any documentation from hospice. Director A said s/he looked through the facility and could not locate the hospice records. S/he explained there was a "hospice binder" that was kept in Resident 1's room and it may have been sent with him/her at the time of discharge. Director A did not provide information about what the hospice plan of care was for fall prevention. SOURCE: According to the publication titled "Falls in Assisted Living Facilities" last revised 02/2022, "Falls resulting in serious injury or death continue to occur in assisted living settings. For this reason, the Division of Quality Assurance (DQA) is reminding assisted living providers of the need to identify residents at risk for falls and to implement strategies for falls prevention ...Once risks are identified, the resident's individual service plan (ISP) should contain approaches to prevent falls from occurring. The following are some examples of interventions ...anticipation of needs, including position changes and ambulation, toileting, food or fluids. Physical assistance with daily living activities. Supervision ...Every fall should result in a post-fall	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 389	Continued From page 39 assessment to determine the cause of the fall and the need for additional or modified interventions. Comprehensive reporting information will identify the date, time, environmental status, and physical or mental condition of the person prior to the fall. Review of those assessments can also reveal a pattern associated with time, place, and staff present ...If a resident is not following a recommended safety plan, a re-assessment may be needed to identify alternative, more effective approaches. A risk engaged by a resident will not eliminate provider liability if there is a negligence that results in harm or if there is a violation of regulatory requirements. IN SUMMARY: Resident 1 was known to be at risk for falls due to self-transferring. The ISP dated 07/02/204 identified the risk but did not document interventions based on assessment to prevent falls. Subsequently, there were 5 more times when Resident 1 was found on the ground after an apparent effort to self-transfer. An intervention of posting a "call don't fall" sign was documented in a fall report dated 08/04/2024 and sometime after 08/27/2024 hospice implemented an intervention of a chair alarm. The ISP was not updated to include the interventions. In addition, a root cause assessment was not conducted to determine why Resident 1 was inclined to self-transfer instead of calling for assistance. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 415}	Continued From page 40	{N 415}		
{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 record review and interview, the provider did not ensure the person administering a medication or treatment accurately 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 August, September and October MARs for Resident 1. The provider did not ensure MARs accurately documented administration of 4 medications for Resident 3. On 10/13 and 10/14/2024, Director A, Caregiver J and Caregiver M all falsely documented medications were administered that were not.	{N 415}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 415}	Continued From page 41 This is a repeat deficiency. See SOD BBRH11, dated 06/10/2024. Findings include: Prior to the onsite visit, Surveyor reviewed the deficiencies from the previous survey (SOD BBRH11, dated 06/10/2024.) A deficiency was identified related to the provider not listing Resident 1's prescribed oxygen on the MAR. RESIDENT 1: Surveyor reviewed Resident 1's facility file on 10/23/2024 at 3:10 PM. The MARs for August, September and October (through 10/17) 2024, did not list oxygen as a prescribed medication/treatment. The most recent physical was dated 11/07/2023. The document noted, "Dependence on supplemental oxygen" and "oxygen 2 LITERS" was listed on the medication list. There were no hospice records or medications orders in the file. Surveyor conducted a joint interview with Director A and Caregiver J on 10/23/2024 at 3:10 PM. Director A confirmed Resident 1 continued to have prescribed oxygen since the last survey in June 2024. S/he stated at first it was PRN (as needed) but after admission to hospice on 08/27/2024, it was changed to continuous. Surveyor asked how many liters per minute Resident 1 was prescribed and Director A said s/he thought it was 2 liters. Caregiver J said, "every time I looked at it, it was 2 liters." Director A confirmed oxygen was not listed on the MARs. RESIDENT 3: Director A showed a text string to Surveyor on 10/23/2024 at 9:10 AM. Surveyor noted the	{N 415}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 415}	Continued From page 42 following: 10/14/2024 at 7:21 PM - Caregiver J to Director A and Assistant Director G, "[Resident 3] did not get [his/her] noon meds today, I poped [sic] them and got rid of them. [Resident 3] also did not get [his/her] 8pm narcotic last night either." Assistant Director G replied, "Oh that's great." Director A replied, "The noon med is between me and [Assistant Director K]" Caregiver J replied, "just sign our the noon when you come in tomorrow, and I got rid of them. you can see per the narc (narcotic) book that [Resident 3] missed the doze cuz [Caregiver L] was the last one to sign for it." [sic - all] Surveyor reviewed Resident 3's October 2024 MAR on 10/25/2024 at 8:00 AM and noted the following: 12:00 PM medications were acetaminophen 500 mg tablet every 4 hours, gabapentin 600 mg tablet once daily and furosemide 20 mg twice daily. All three medications were documented as administered by Director A on 10/14/2024 at 12:00 PM. 8:00 PM medications included tramadol (narcotic) 50 mg twice daily. Tramadol was documented as administered by Caregiver M on 10/13/2024 at 8:00 PM. Surveyor interviewed Director A on 10/29/2024 at 8:04 AM and asked about the text exchange and what s/he meant by the noon medications being between him/her and Assistant Director K. Director A said s/he meant s/he would follow up with Assistant Director K because s/he was the one administering medications. Surveyor asked if s/he followed up as intended and s/he replied, "I don't remember if I did." Surveyor asked about Director A's initials on the MAR for the noon	{N 415}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011953	A. BUILDING: _____ B. WING _____	R-C 11/04/2024

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 415}	Continued From page 43 medications. S/he replied, "Oh, I didn't circle them (indicating they weren't given). That's on me." Surveyor also asked about Resident 3's 8:00 PM tramadol on 10/13/2024. S/he acknowledged it was documented as administered by Caregiver M. Director A said s/he hadn't yet looked into the situation as reported by Caregiver J. During the interview Director A retrieved the "Controlled Substance Proof of Use Form" for Resident 3's tramadol. S/he stated the medication was signed out as administered on 10/12/2024 by Caregiver L and on 10/13/2024 by Caregiver J. Director A confirmed this charting was inconsistent with Caregiver J's text message on 10/14/2024 stating the medication was not given on 10/13/2024 and Caregiver J, "got rid of them." Upon request, Director A emailed Surveyor the proof of use form on 10/29/2024 at 8:24 AM. Surveyor confirmed Caregiver J signed and dated the form 10/13/2024, falsely documenting s/he administered the tramadol. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations	{N 415}		