STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013172	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE LANE HOUSE	1707 CARRIE LN WEST BEND, WI 53095

(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 04/29/2025, Surveyor conducted a complaint investigation at Carrie Lane House. Additional information was received through 04/30/2025. The complaint was substantiated and 2 deficiencies were identified. Census: 7	N 000		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure Resident 1's individual service plan (ISP) was updated to reflect his/her current needs or physical condition. Resident 1's most current ISP was dated 07/26/2024 and was not updated to (1) identify his/her dietary needs for thickened liquids or (2) to identify interventions to prevent worsening of a current pressure injury or the development of new pressure injuries.	N 389		

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

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N 389	Continued From page 1 Findings include: On 04/16/2025, the department received a complaint alleging care concerns. THICKENED LIQUIDS: On 04/29/2025 at 7:48 AM, Surveyor observed Assistant Administrator (AA) F prepare a drink for Resident 1. S/he added 2 medications in powder form and 2 scoops (1 tablespoon/tbsp each) of Thick It to a cup with approximately 8 oz of water in it. (Thick It is a beverage thickener for individuals with difficulty safely swallowing.) Surveyor observed the medication administration record (MAR) prompted for "THICK IT - USE AS DIRECTED TO MAKE HONEY THICK LIQUIDS." AA F gave the liquid to Caregiver A to offer to Resident 1 with breakfast. At 8:01 AM, Surveyor observed Caregiver A feeding Resident 1. Surveyor tested the consistency of the liquid in the cup by swirling it, and noted it was thin and free moving in the cup. Caregiver A confirmed the liquid was the normal consistency and they always add 2 tablespoons to 8-10 oz of water. At 10:11 AM, Caregiver A retrieved Resident 1's record (a binder) from a locked closet containing other resident records. Surveyor did not locate an ISP in the binder. Caregiver A confirmed it was not in there and said s/he wasn't sure s/he'd ever seen one for Resident 1. The binder contained 1 page document from the International Dyshagia Diet Standardization Initiative (IDDSI.) The document had a triangular chart identifying 5 thickness levels and read, "My IDDSI drink level is 3...moderately thick." SURVEYOR NOTE: Level 3 "Can be drunk from a cup or taken with a	N 389		

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N 389	Continued From page 2	N 389		

spoon. Need some effort to drink them through a wide diameter straw. Have a smooth texture..." Source https://www.iddsi.org. Retrieval date, 04/30/2025.) The document was not dated or signed, but included the name and phone number of Resident 1's physician.

At 11:37 AM, Surveyor and Caregiver A observed the container of Thick It. The container included the same IDDSI triangular chart. Instructions on the container for moderately thick liquids were 4.5-5.5 teaspoons (tsp) for every 4 oz of liquid. Surveyor noted that when doubling the liquid from 4 oz to 8 oz and converting from tsp to tbsp (1 tsp = 3 tbsp), Resident 1's drink should have been prepared with approximately 3 tbps instead of 2 tbsp.

Surveyor asked AA F to provide the current order for Thick It and Resident 1's current ISP.

AA F printed a pharmacy document (at 1:15 PM) which mirrored the instructions on the MAR for honey thick liquids and to follow the directions on the package. AA F said the order had been in place for years, and the IDDSI printout in the records was provided by Resident 1's doctor to further clarify the necessary thickness. AA F could not recall when s/he received the IDDSI printout.

AA F retrieved an ISP (at 10:15 AM) from his/her office and said it was current. The ISP was dated 07/26/2024 and was not signed by Resident 1 or his/her legal representative. AA F said s/he mailed the ISP to the guardian for review and signature in August 2024 and never heard back. The ISP identified needs around solid foods, "Resident is to have pureed diet. Resident has Dysphagia-High Risk of aspiration/Chocking"

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N 389	Continued From page 3 [sic], but was silent to needs for thickened liquids. AA F confirmed Surveyor's review of the ISP. AA F said s/he would obtain a current, signed order from the physician and update the ISP with the information to ensure Resident 1's needs were met for thickened liquids. PRESSURE INJURIES: Surveyor interviewed Caregiver A on 04/29/2025 at 8:44 AM. Caregiver A described Resident 1 as being fully dependent on staff assistance with all activities of daily living including transfers and repositioning. Caregiver A said Resident 1 is prone to pressure injuries and currently has one on his/her tailbone area and another where his/her thigh meets the buttocks. Caregiver A explained Resident 1 receives wound care 3 times/week from home health registered nurse (RN) E, and RN E has instructed Resident 1 should be in bed with the exception 2-3 hours/day. This is to limit the time s/he is sitting and applying pressure to tailbone. Caregiver A when Resident 1 is out of bed, s/he uses a thick cushion in a special wheelchair that allows different reclining levels to relieve pressure. While in bed, Resident 1 should be propped in alternating positions on his/her right and left side, every 2 hours. Caregiver A said sometimes Resident 1 cries when s/he is repositioned on the left side because s/he doesn't like facing the wall. Caregiver A said s/he bought a tapestry for the wall to try to give Resident 1 something interesting to look at. Caregiver A also said s/he does not think night shift repositions like they are supposed to. Surveyor reviewed portions of Resident 1's record on 04/29/2025 at 10:11 AM. Resident 1 had	N 389		

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N 389	Continued From page 4 diagnoses to include quadriplegia (paralysis of all 4 limbs) and Cerebral Palsy. The MAR read, "MAKE SLIGHT CHANGES IN POSITION EVERY HOUR WHILE IN WHEELCHAIR, REPOSITION EVERY 2 HOURS WHILE IN BED" and prompted for caregivers to initial once per shift. In addition, the record contained a "Rotation Log" for April 2025. The log contained hourly time slots but did not specify the frequency Resident 1 should be repositioned or if the frequency changed if s/he was in bed versus the wheelchair. The log was not consistently filled out. Sometimes caregivers initialed hourly (including during the overnight shifts), sometimes every 2 hours and some days/shifts were left blank. Surveyor interviewed RN E at 11:59 AM. S/he confirmed Resident 1 was prone to pressure injuries due to his/her paralysis and frail skin. RN E said Resident 1's tailbone area is always prone to opening up and requires a mepilex bandage to protect the area. RN E said s/he is responsible for changing the bandage, but staff would also need to change it if it became soiled between RN E's visits. RN E said Resident 1 currently has an open area in the left gluteal fold that s/he also cares for. RN E said Resident 1 needs several interventions to manage and prevent pressure injuries. This include the need for staff to reposition Resident 1 every 2 hours. RN E added that while Resident 1 should not sit for long periods of time, "I think emotionally for [him/her] [s/he] needs to spend a little more time in wheelchair. I recommend at least 3 times a day for meals." On 04/29/2025, Surveyor was present in the facility from 7:35 AM until 11:40 AM. Surveyor	N 389		

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N 389	Continued From page 5 observed Resident 1 was fed breakfast in bed and was not transferred into his/her wheelchair during this time. Surveyor interviewed AA F at 1:18 PM. S/he explained s/he shared Caregiver A's suspicions that Caregiver C was not repositioning Resident 1 during the overnight and questioned the accuracy of Caregiver C's charting. During the aforementioned review of the current ISP dated 07/26/2024, Surveyor noted the following: --"Palm Protectors: Resident wears palm protectors daily." --"Heal Protector: Resident wears protector to prevent pressure ulcer on right foot." --"maintain good body hygiene as evidenced by skin being absent of redness/open areas...monitor resident's skin integrity daily to assure there is not skin breakdown..." Resident 1's ISP did not identify: --the history of pressure injuries on the tailbone --the current pressure injury on his/her left gluteal fold --strategies to prevent worsening or new injuries, such as frequent repositioning --the frequency or amount of time Resident 1 could be out of bed and in his/her wheelchair AA F confirmed Surveyor's review of the ISP. S/he explained s/he has been overwhelmed with oversight tasks at the facility and has fallen behind on ISPs	N 389		
Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident	Y3234		

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Y3234	Continued From page 6 in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. This Rule is not met as evidenced by: Based on interviews and record review, the provider did not ensure every resident was treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employees of the facility. Caregiver C and Caregiver D did not treat Residents 1, 2, 3 or 4 with courtesy, respect or with full recognition of the resident's dignity and individuality. Findings include: On 04/16/2025, the department received a complaint alleging verbal abuse was occurring at the facility and staff were not allowing residents to listen to their preferred music. The provider is licensed to serve up to 8 individuals from the following client groups;	Y3234		

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advanced age, physically disabled, irreversible dementia/Alzheimer's, developmentally disabled and traumatic brain injury.

CAREGIVER C

Between 7:48 AM and 8:01 AM on 04/29/2025, Surveyor observed Resident 1's interactions with staff. S/he communicated with staff by nodding yes or shaking his/her head no and was fed a pureed breakfast by Caregiver A. Surveyor reviewed Resident 1's current ISP dated 07/26/2024, which documented diagnoses to include quadriplegia and cerebral palsy. It noted Resident 1 was "semi-non-verbal" with the ability to communicate yes and no. The ISP indicated staff should smile and speak slowly and pleasantly to Resident 1.

Surveyor interviewed Resident 1 at 11:25 AM. Surveyor asked Resident 1 if s/he liked living at the facility, s/he nodded yes. Surveyor asked if s/he liked different staff including Caregiver A and Assistant Administrator (AA) F, and s/he nodded yes. Surveyor asked if staff grind up his/her food, s/he nodded yes. Surveyor asked Resident 1 if s/he liked Caregiver C. Resident 1's facial expression changed, s/he looked distressed and shook his/her head no. Surveyor asked if s/he could say why and s/he replied, "Yells." Surveyor asked for confirmation s/he was saying Caregiver C yells, and Resident 1 nodded yes. Surveyor asked if Caregiver C was gentle while providing cares and Resident 1 shook his/her head no.

Surveyor interviewed Caregiver A on 04/29/2025 at 8:44 AM. Caregiver A said s/he has concerns with Caregiver C's treatment of residents. S/he described an example on 04/25/2025 when Caregiver C said s/he would "deal with" a resident

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Y3234	Continued From page 8	Y3234		

and referred to the resident as a "fat [expletive]." Caregiver A said residents did not hear the exchange but it was very upsetting and Caregiver A started to cry. S/he volunteered, "[Caregiver C] says some awful things." Caregiver A stated Resident 2 reports Caregiver C "screams" at Resident 2 "the whole time" when helping him/her out of bed. Caregiver C continued to cry and said the residents deserve better. Caregiver A commented, "[Resident 2] was excited when I told [him/her] I was working tonight" and was relieved it wasn't Caregiver C. Caregiver A explained s/he is especially concerned for the wellbeing of the residents because Caregiver C works alone during 3rd shift.

Surveyor interviewed Resident 2 at 3:06 PM. Surveyor observed s/he was in a wheelchair and a mechanical lift was present in the room for transfers. Resident 2 volunteered a concern about Caregiver C swearing loudly and talking disrespectfully about Resident 3. Resident 2 explained sometimes Resident 3 uses the restroom at night and accidentally gets feces on the toilet. In the morning when Caregiver C checks the bathroom s/he will complain loudly and say things like, "[Expletive]...why don't you hit the toilet! Can't you make it to the toilet?"

Resident 2 said Caregiver C also swears directly at him/her (Resident 2) while providing cares. Caregiver C will say, "If I didn't have to [expletive] take care of you" and then "goes on about how [s/he] has to take care of me." Resident 2 said s/he often thinks Caregiver C would be in trouble if other people heard the way s/he swears at him/her. Resident 2 stated it makes him/her feel terrible but "I just let [him/her] rant and rave, otherwise [s/he] will write me up (incident report.)" Resident 2 said s/he has reported concerns to

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Assistant Administrator (AA) F as recently as the previous week, but nothing has changed.

Surveyor interviewed Caregiver B on 04/30/2025 at 10:17 AM. S/he stated, "[Caregiver C] is very mean to [Resident 2]" and recently s/he observed Caregiver C "yelling at [Resident 2]" during a transfer saying, "You need to be helping me. You can't just not be helping!" Caregiver B explained Resident 2 has trouble picking up his/her legs. Caregiver B also stated s/he was present during the 04/25/2025 incident described by Caregiver A, when Caregiver C referred to a resident in a derogatory way. Caregiver B said, "It makes me sad."

CAREGIVER D

During the aforementioned interview with Caregiver A, s/he also volunteered concerns with Caregiver D. Caregiver A said Resident 3 will ask who is working 2nd shift and when it's Caregiver D s/he says, "I hate that [girl/guy]. [S/he] is so mean to us." Caregiver A said s/he has told AA F that Resident 3 doesn't like Caregiver D.

On 04/29/2025 at 3:00 PM, Surveyor observed Resident 3 return home from day program and go to the back patio with a guitar, a CD player and 2 CDs. Surveyor attempted to interview Resident 3. Surveyor observed s/he was focused on playing his/her music and provided one word answers to Surveyor's questions. Surveyor asked Resident 3 if s/he liked the staff and listed some names including AA F and Caregiver C. Resident 3 smiled in response and said yes, s/he liked them. However, when Surveyor asked about Caregiver D s/he replied Caregiver D was "OK" and did not smile. Surveyor asked Resident 3 what kind of music s/he was intending to listen to. S/he smiled

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Y3234	Continued From page 10	Y3234		

and said the CDs were jazz and blues.

During the aforementioned interview with Caregiver B, s/he expressed concerns about Caregiver D's treatment of residents and described him/her as "rude...[s/he] just degrades them." Caregiver B gave an example of an incident a "few weeks ago" when Resident 3 reported Caregiver D told him/her s/he couldn't play his/her music and should play the music Caregiver D liked. Caregiver B said, "I told [Resident 3] [s/he] could play whatever music [s/he] wanted" and described how music is very important to Resident 3.

Caregiver B sent Surveyor a screen shot of a text message s/he sent to another caregiver about Caregiver D and Resident 3. The text read, "[Resident 3] got home and first thing [s/he] said was [s/he] is not a fan...of [Caregiver D] and that made me sad." Caregiver B sent a second message dated 04/14/2025 sent to 2 caregivers, complaining to them about the incident where Resident 3 said Caregiver D told him/her to stop listening to his/her preferred music.

Caregiver B reported a similar concern to Surveyor with Resident 4 that occurred around the same time. Caregiver D said when staff do bedtime cares for Resident 4, they turn on the radio which is always tuned to a "mellow country" station that Resident 4 likes. One night when s/he worked after Caregiver D, the radio was set to 100.7 which plays rap music. Caregiver D said Resident 4 would not have the ability to know how to change his/her radio station and s/he reported the concern to AA F. Caregiver B sent Surveyor a screen shot of a snap chat message s/he sent to 2 other caregivers on 04/14/2025. It was a photo of a radio turned to 100.7 and text that read, "Last

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Y3234	Continued From page 11 time...[Caregiver D] put Resident 4] to bed they turned on Y100..." RECORD REVIEW Surveyor reviewed Caregiver C's complete record on 04/29/2025 at 10:58 AM. A performance review dated 06/02/2024 read in part, "Constructive Criticism: Just watch your tone w/resident's families & maybe it would be helpful to address them as if they were your boss?" [sic - all] Surveyor reviewed Caregiver D's complete on 04/29/2025 at 11:10 AM. A performance evaluation dated 04/18/2025 documented concerns about him/her wearing headphones while working. INTERVIEW WITH AA F Surveyor interviewed AA F on 04/29/2025 at 1:18 PM: AA F acknowledged concerns in the past about Caregiver C's "tone" and in the past 2 weeks s/he suspected Caregiver C was sleeping during 3rd shift. AA F said s/he was not aware of allegations Caregiver C yelled or was otherwise mistreating residents. Surveyor informed AA F of the interview with Resident 1. AA F started to cry. S/he said, "I feel like its on me. I'm missing something. I feel like if [Resident 1] said that, it was recent" and explained Resident 1 only talks when s/he has something important to say and if it was a recent event. While discussing Resident 2, AA F said s/he was his/her own legal decision maker and had "ears like a hawk." AA F said Resident 2 had expressed some concerns about Caregiver C debating with	Y3234		

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Y3234	Continued From page 12 him/her over how to provide cares, but s/he had not yet looked into the matter. Surveyor conducted a follow up interview with AA F on 04/30/2025 at 3:40 PM: AA F said music is very important to Resident 3 and it would be troubling if staff were discouraging him/her in any way from playing his/her preferred music. AA F acknowledged previous concerns about Caregiver D wearing headphones and listening to music because s/he was not able to hear if residents needed him/her. AA F said s/he was aware of the incident with Resident 4's radio. S/he confirmed Resident 4 prefers county music and has never requested or listened to rap music. AA F said Resident 4 has the "mental capacity of a 5 year old" and it would be unusual for staff to even offer him/her a different type of music, especially at bedtime when the goal of the music is to calm him/her. AA F acknowledged, "Over the past few weeks I had the sense things weren't good." AA F said s/he would take immediate steps to thoroughly investigate the concerns involving both caregivers.	Y3234		