STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018123	A. BUILDING: _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTFORD ESTATES II	111 LONE OAK LANE HARTFORD, WI 53027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 06/07/2024 to 06/13/2024, Surveyor conducted a complaint investigation at Hartford Estates II. Two deficiencies were identified. The complaint was substantiated. Census: 6	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure when the CBRF received a report of an allegation of abuse of a resident by	N 158		

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

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N 158	Continued From page 1 a caregiver, the CBRF investigated the allegation timely or thoroughly or took immediate steps to ensure the safety of all residents in 1 of 1 incident reviewed. Findings include: On 06/07/2024 at 10:15 AM, Surveyor interviewed Resident 1. Resident 1 asked the Surveyor if s/he was visiting today after reporting a caregiver misconduct concern to his/her home health agency. Surveyor said "no" but asked Resident 1 to share his/her concerns. Resident 1 stated s/he was upset how the provider handled a recent confrontation s/he had with Caregiver B. Resident 1 stated on 05/12/2024, s/he got into a verbal argument with Caregiver B over the temperature inside the facility. Resident 1 reported s/he often gets hot and requests staff to turn down the thermostat from 74 degrees. Resident 1 reported Caregiver B said, "You're such a [expletive] [expletive], what are your going to do?" Resident 1 stated s/he texted Administrator A about the incident because s/he was on vacation out of state. Resident 1 stated Administrator A noted s/he would do a complete investigation once s/he returned from vacation. Resident 1 noted Caregiver B continued to work like nothing happened. On 06/07/2024, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted to the facility on 09/01/2020 with diagnoses of diabetes type II, post-traumatic stress disorder, and anxiety. Resident 1 is their own legal decision maker. A review of the provider's investigation dated 05/21/2024 documented:	N 158		

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N 158	Continued From page 2 "Report: Allegations were made that [Resident 1] and staff member [Caregiver B] got into a disagreement about the thermostat not being set to state regulations. Resident stated [s/he] was hot and asked staff member to turn down the thermostat. According to staff, resident asked and staff member declined stating [s/he] did not have the key. Resident got upset and told staff member what the regulation was and that [s/he] couldn't do that. Staff did admit to swearing as [s/he] was walking away-citing [s/he] doesn't remember exactly what was said. According to resident, staff stated something like, 'You're a [expletive] [expletive].' I [Administrator A] was in another state on vacation at the time of this incident. I [Administrator A] notified resident's care team, while out of state, talked to both staff member and resident. Upon my arrival home, today May 21, 2024, I talked to both parties involved. Findings: Claim is substantiated that words were exchanged between the two involved. Staff member was told this will be [his/her] only warning or [s/he] will be terminated for resident verbal abuse. Because [s/he] was walking away and no other residents have substantiated exact words; a verbal warning is being given. Resident is satisfied with the outcome of the investigation. And is assured that this behavior will not be tolerated by anyone in or around the provider." Surveyor reviewed the provider's staff schedule from 05/12/2024 to 05/21/2024. The schedule documented Caregiver B worked on 05/12/2024 from 7-3pm, 05/14/2024 from 3-11pm, 05/15/2024 from 3-11pm, and 05/16/2024 from 7-3pm, indicating the provider allowed Caregiver B to continue to work after being made aware of misconduct allegation.	N 158		

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N 158	Continued From page 3 On 06/07/2024 at 12:52 PM, Surveyor interviewed Administrator A regarding Resident 1's allegation of caregiver misconduct. Administrator A stated s/he was out of state on vacation when becoming aware of Resident 1's allegation. Administrator A stated s/he was made aware of the incident on 05/13/2024 and the next day, care teams were notified. Administrator A stated s/he spoke to Resident 1 via text message after learning about the allegations and s/he tried to call Caregiver B. Administrator A stated once s/he returned on 05/21/2024 a full investigation was conducted which noted words were said between Resident 1 and Caregiver B but unable to prove what was said. Surveyor asked how the provider safeguarded residents from the possibility of further verbal abuse when they allowed Caregiver B to return to work on 5/14, 5/15, and 5/16. Surveyor expressed concern an investigation was not conducted timely or thoroughly since Administrator A did not delegate the responsibility for an investigation and waited until 5/21 upon returning from their vacation. Administrator A stated s/he talked to Resident 1 after learning of allegation and s/he was okay with outcome to wait for an investigation upon my return. Surveyor stated Resident 1 showed the Surveyor text messages between Resident 1 and Administrator A, which noted Administrator A was turning their phone back on airplane mode and we would talk about this once I return. Surveyor stated Resident 1's record did not contain evidence Caregiver B was contacted about the misconduct allegation until 5/21. Administrator A continued to state both Resident 1 and Caregiver B were contacted following learning of allegations and both were over the incident. Administrator A confirmed s/he did not delegate another staff member to conduct an investigation and did not	N 158		

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N 158	Continued From page 4 suspend Caregiver B pending the outcome of the investigation. Administrator A stated s/he finished and documented the investigation on 5/21/24.	N 158		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure at least 1 qualified care staff was on duty and awake when at least 1 resident in the CBRF was in need of supervision or intervention on a 24-hour basis for an intermittent mental or physical condition that may occur, including residents who had unstable	N 397		

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N 397	Continued From page 5	N 397		

health conditions that required close monitoring. Caregiver C was observed sleeping during the 3rd shift on 05/08/2024.

Finings include:

On 03/12/2024, the Department received a complaint alleging Caregiver C was sleeping on the job.

On 06/07/2024, Surveyor conducted a complaint investigation and identified the following:

The provider is licensed to serve up to 6 residents within the client groups of irreversible dementia/Alzheimer's, traumatic brain injury, developmentally disabled, physically disabled, advanced age, and terminally ill.

The provider's program statement stated, "At least one awake staff will be on duty 24 hours per day when residents are present in the home. Additional staff may be added as dictated by resident needs, acuity and care plans in order to accomplish individual program goals as provided for within the context of their individual support plan (ISP)."

On 06/07/2024 at 10:15 AM, Surveyor interviewed Resident 1 regarding staff sleeping on the job. Resident 1 stated s/he had caught Caregiver C multiple times sleeping during the 3rd shift. Resident 1 stated Caregiver C is the spouse of Administrator A, so s/he does not like to report these concerns. Resident 1 stated s/he did report Caregiver C for sleeping sometime in 2023. Resident 1 stated s/he took a picture of Caregiver C sleeping on the 3rd shift approximately a month ago. Resident 1 stated s/he would share the photo with the Surveyor.

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N 397	Continued From page 6 On 06/07/2024 at 11:00 AM, Surveyor interviewed Resident 2 in his/her bedroom. Resident 2 was observed using an oxygen concentrator. Resident 2 stated s/he used the concentrator 24/7. Resident 2 stated s/he does not often wake up during 3rd shift, but at times if requesting an as needed inhaler it could take 20-30 minutes. Resident 2 stated due to his/her breathing concerns, s/he required health monitoring by the facility. On 06/07/2024 at 12:00 PM, Surveyor interviewed Resident 3. Resident 3 stated s/he had observed Caregiver B sleeping on the couch in the living room a few times. Caregiver B stated s/he did not report these concerns to Administrator A because Caregiver B was his/her spouse. Resident 3 stated Caregiver B would often do double shifts and would be tired overnight. On 06/07/2024 at 2:27 PM, Surveyor received an emailed photo from Resident 1. The photo was taken on 05/08/2024 at 1:55 AM and showed Caregiver B sleeping on the couch at the facility. The couch, end table, and curtains observed in the photo matched an area in the living room at the facility. Surveyor observed the area identified in the picture during on-site survey. Surveyor reviewed the provider's staff schedule for May 2024. The schedule noted Caregiver B worked on 05/07/2024 from 3:00 PM until 05/08/2024 at 7:00 AM. On 06/13/2024 at 3:03 PM, Surveyor conducted an exit conference and shared findings with Administrator A. Administrator A confirmed Caregiver B was his/her spouse and was aware	N 397		

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N 397	Continued From page 7 of 1 incident in 2023 with Caregiver B sleeping. Administrator A stated Caregiver B was given a verbal warning and s/he had not heard any other concerns since. Surveyor asked Administrator A about the provider's staffing patterns. Administrator A stated 1 caregiver is scheduled to be awake each shift (7-3, 3-11, 11-7). Surveyor expressed concern the facility was not staffed with awake staff on 05/08/2024 as indicated on the program statement and based on Resident 2's comment of health monitoring was required by the facility. Administrator A acknowledged the program statement the facility would have awake staff and some residents required 24-hour supervision. Administrator A stated s/he was unaware of Caregiver B sleeping on 05/08/2024 until day of survey. Surveyor noted after several resident interviews, residents were afraid to express concerns to Administrator A because Caregiver B was his/her spouse and did not want to get in trouble. Administrator A acknowledged the resident concerns but stated, "I still wished they would have come to me."	N 397		