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N 000	Initial Comments An abbreviated survey and an investigation into 6 complaints was conducted on 02/17/2025 with information gathered through 03/03/2025. As a result of this survey all six complaints were substantiated. Nine (9) deficiencies were identified. Census: 18	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not take immediate steps to ensure the safety of all residents, thoroughly investigate, and maintain documentation of the investigation	N 158		

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

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N 158	Continued From page 1 in response to reports received which alleged potential abuse, neglect and/or mistreatment of residents. On 02/03/2025, Resident 3 reported s/he had to wait over an hour and a half for toileting assistance and laid in a wet bed/cloths until Caregiver F arrived. Once Caregiver F arrived Resident 3 reported Caregiver F was rough and left the resident lying on a plastic mattress cover, without sheets. Additionally, multiple staff reported when Caregiver F worked residents were found completely soaked in urine and medications were not being signed out. After learning of the concerns, the provider did not conduct or document a thorough investigation into the incident with Resident 3 or the allegations made by multiple facility staff to rule out caregiver misconduct and to determine if the incident(s) were reportable. The provider did not take immediate steps to protect all residents from subsequent incidents of misconduct when Caregiver F continued to work alone, providing direct resident care until the morning of 02/18/2025, when Executive Director A terminated his/her employment. On 02/04/2025, Resident 1 reported s/he had to wait overnight in a soiled brief after notifying caregiver that s/he required assistance with toileting. After learning of the concerns, the provider did not conduct or document a thorough investigation into the incident with Resident 1. Cranberry Court II has had a regular Class CNA (non-ambulatory) CBRF license since 08/01/2016 for the capacity of 22 residents who are terminally ill, physically disabled, advanced aged, developmentally disabled, emotionally disturbed/mental illness, and/or have irreversible	N 158		

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N 158	Continued From page 2	N 158		

dementia/Alzheimer's disease. The facility is located on the same grounds as Cranberry Court I (a sister facility with a paved walkway located between the two facilities).

Findings include:

On 01/10/2025, 01/13/2025, 01/15/2025 and 02/05/2025. The Department received concerns regarding residents' personal cares not being done and residents waiting for extended periods of time for staff assistance.

On 02/18/2025, Surveyor reviewed the facility's policy and procedure titled Prevention of Abuse, Neglect and Exploitation of Residents, revised 01/22/2025 which stated, "This community to encourage and support all residents, staff, and families in feeling free to report any suspected acts of abuse, neglect, involuntary seclusion, misappropriation of property, or a complaint related to resident care. The community will take all measures possible to assure residents, staff, and families are free from fear of retribution if reports or incidents are reported to the community...The community will thoroughly investigate any and all reports of abuse, neglect, and misappropriation of property...PROCEDURE: ...2. Any community employee(s) witnessing or having knowledge of potential or actual abuse, neglect and/or exploitation must immediately report the incident to the Executive Director, Wellness Director and/or designee. If applicable, employee must take immediate action to stop the suspected abuse, neglect or exploitation. 3. If a resident, family member or visitor witnesses or has knowledge of any potential or actual abuse, neglect or exploitation of a resident, he/she may report the incident to any community employee who will, in turn, report it to the Executive

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N 158	Continued From page 3 Director, Wellness Director and/or designee immediately...5. Upon learning of an incident, the Executive Director, Wellness Director and/or designee will ensure that steps have been taken to ensure the alleged victim(s) and potential victims have been protected from harm. a. If the alleged perpetrator is a community employee, the employee will be placed on suspension until the investigation has been completed...6. The Executive Director, Wellness Director and/or designee will conduct an investigation to complete and submit a report of the alleged or suspected abuse of, neglect of, exploitation of and/or misappropriation from the resident: a. If CBRF Resident, no later than five (5) calendar days ...to the State of Wisconsin Department ...C. As soon as practicable, but no later than seven (7) calendar days to the Resident/Responsible Party who is the alleged victim of abuse, neglect, exploitation or misappropriation that an allegation has been made a report is being forwarded to the appropriate authority ..." On 02/18/2025, Surveyor reviewed the Department's Caregiver Program Manual, a resource for providers last revised 10/2024. It read in part, "ENTITY INTERNAL INVESTIGATION RESPONSIBILITIES-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...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 including videos; Interviewing alleged victims and witnesses; Collecting other corroborating/disproving	N 158		

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evidence; Involving other regulatory authorities who can assist...e.g., local law enforcement...; 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 (Office of Caregiver Quality)..."

EXAMPLE 1

On 02/17/2025, Surveyor reviewed Resident 3's medical record. Resident 3 was admitted to the facility on 09/27/2024 with diagnoses to include diabetes, heart failure and unsteadiness on feet. Resident 3 was his/her own person and able to make her/his needs known. Resident 3's ISP dated 12/04/2024, indicated the resident has a call light in room, a wheelchair for mobility and required assistance with dressing, bathing, and toileting. Additionally, the ISP indicated Resident 3 was continent of bladder and bowel, required the assistance of one staff and a pivot disc for transfers, and noted, "Resident will call when toileting assistance is needed."

On 02/18/2025 at 8:52 AM, Surveyor interviewed Resident 3 regarding the care and treatment s/he receives at the facility. Resident 3 stated, "I had a bad night with [Caregiver F] the first week of February 2025. I had to wait over an hour and a half for [her/him] to help me with toileting and had to sit in a wet bed the entire time. When [Caregiver F] did come in [s/he] was pretty rough with me. [Caregiver F] has been verbally abusive with other residents. I've told staff I never want [Caregiver F] near me. I wrote up a grievance on

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N 158	Continued From page 5 [Caregiver F] and gave it to [Lead Caregiver/Activities Director C], but never heard back from anyone not even [Executive Director A] and [Caregiver F] is still working because they are short of staff ..." On 02/17/2025 at 1:41 PM, Surveyor interviewed Resident 7 regarding the care and treatment s/he receives at the facility. Resident 7 stated, "The overnight crew is not too good. One staff [Caregiver F] does not do anything. [Caregiver F] works overnight, and you have to keep calling [her/him] every 20-30 minutes to get [her/him] to come. [Caregiver F] worked last night. [Caregiver F] does not check on you as much, does not empty my urinal every two hours and does not do much." On 02/17/2025 at 2 PM, Surveyor interviewed Caregiver D. Caregiver D stated, "When I arrived for my shift this morning all the residents were soaking wet. Residents' bedding and briefs were sopping wet ...[Caregiver F] worked alone last night, and this happens often when [Caregiver F] works. I've told [Executive Director A] about this multiple times in person, but [Caregiver F] just keeps working and nothing changes. Caregiver D then showed Surveyor a text message from Caregiver D to Executive Director A. The text message revealed on 02/07/2025 at 7:41 AM Caregiver D messaged Executive Director A, "When I came in at 6:01 AM everyone was soaked, and nobody was dressed. Executive Director A responded, "Who worked last night." Caregiver D stated, "[Caregiver F]." Surveyor then asked Caregiver D if s/he was interviewed regarding what s/he knew, witnessed and/or provided a written statement. Caregiver D stated, "I was never interviewed or asked to write a statement. No one asked me for details."	N 158		

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N 158	Continued From page 6 On 02/17/2025 at 2:30 PM, Surveyor interviewed Caregiver B. Caregiver B stated, "[Caregiver F] left a mess this morning ... Residents were found soiled and sopping wet with urine and a medication for [Resident 2] was given inappropriately. [Caregiver D] and I informed [Executive Director A] right away this morning about what we found." Caregiver B went on to say, "Residents are not getting changed on nights when [Caregiver F] works, and this has been happening for weeks ...When I do rounds in the morning after [Caregiver F] leaves, residents have wet briefs, some resident's beds are soaking wet or their chux pads are brown from urine sitting for 8 hours." Surveyor then asked if this information was reported to anyone. Caregiver B stated, "I've told [Executive Director A] and [Business Office Manager G], but they never listen or change anything." Surveyor questioned Caregiver B if s/he was interviewed or asked to write a written statement regarding what s/he witnessed and knew about these incidences with [Caregiver F]. Caregiver B stated, "I've reported the information to [Executive Director A], but I'm not questioned or asked to write a written statement. I'm just told, OK we will work on it, but nothing changes." On 02/18/2025 at 2:12 PM, Surveyor interviewed Caregiver E. Caregiver E stated, "I've come into work after [Caregiver F's] shift and find residents soaked in urine. When I asked [Caregiver F] if Residents were changed, [s/he] will say [s/he] changed the residents but clearly, [s/he] didn't because I find residents completed soaked with 8 hours' worth of urine and catheter bags full. I also found meds not signed out or possibly given inappropriately when [Caregiver F] worked ...During the night shift on 02/16/2025, I worked	N 158		

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alone in Building 1 and [Caregiver F] worked alone in Building 2. After my 02/16/2025 night shift ended in Building 1, [Caregiver D] asked me to come over to Building 2 to help with 7 AM rounds because [Caregiver F] had to leave. [Caregiver D] and I found residents soaked in urine and catheter bags full and not emptied. When I went in by [Resident 5] [s/he] said [Caregiver F] was mean to [her/him] and ignored [her/him] all night. I also found [Resident 5] to be soaked in urine. I've been telling [Executive Director A] for several weeks now that [Caregiver F] has been neglecting residents and sleeping at night ...Residents have complained to me [Caregiver F] is not providing any cares at night. Some residents can't speak for themselves because they have dementia. [Resident 3] told me [s/he] does not want [Caregiver F] in [her/his] room. Caregiver E went on to say, "I've sent [Executive Director A] text messages about [Caregiver F's] inappropriate behavior at work and a questionable med error with [Resident 8]." Surveyor viewed a text message dated 02/17/2025 at 7:21 AM between Caregiver E and Executive Director A. Caregiver E wrote "This is just insane the way [Caregiver F] screwed over day shift in Building 2. I even checked over at 6 to make sure [s/he] was busy, and [s/he] did nothing. I can't watch [her/him] neglect these guys like this anymore this is so sad." Executive Director A wrote back, "Nothing? Like not a single care." Caregiver F confirmed, s/he reported other incidents of potential misconduct regarding Caregiver F to Executive Director A but was never interviewed or asked to write a written statement. Caregiver E stated, "[Executive Director A] will tell me [s/he] is handling it."

On 02/17/2025 at 3:30 PM, Surveyor interviewed Lead Caregiver/Activities Director C. Lead

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N 158	Continued From page 8 Caregiver/Activities Director C stated, "[Caregiver F] works in both buildings and when [s/he] works residents are soaked in urine and not attended to. I've come in to relieve [Caregiver F] at 7 AM and the residents are not changed and found soaked in urine. This has been an ongoing issue since [Caregiver F] started. During the night shift on 02/07/2025, I did a pop-up visit on [Caregiver F] because I was getting complaints about [her/him]. [Caregiver F] was working alone, and I saw [Caregiver F] sitting on the couch watching TV. I found a resident soaked in urine and another resident half out of the bed. I told [Executive Director A] several times [Caregiver F] doesn't do anything and [s/he] calls residents names and is mean and rough. [Executive Director A] did put up a camera in the facility to keep an eye on [Caregiver F] when [s/he] works ...A lot of staff complained to [Executive Director A] about [Caregiver F] not doing cares and not signing out narcotic medication for [Resident 2]...I don't know why they keep [Caregiver F] ....[Resident 3] has complained to me [Caregiver F] is rough with [her/him], and [s/he] does not feel safe with [Caregiver F]. [Resident 4] told me when [Caregiver F] works during the night shift and [s/he] rings to go to the bathroom, [Caregiver F] tells [Resident 4] to take [her/himself]. [Resident 4] goes to the bathroom in [her/his] brief because [Caregiver F] refuses to help [her/him] to the bathroom." Lead Caregiver/Activities Director C went on to say, "Last week I was on a call with [Business Office Manager G], [Executive Director A] and [Wellness Director H]. We talked about taking [Caregiver F] off all the PM and night shifts and putting [her/him] on AM shifts for more supervision, but that never happened because staff called in sick and [Caregiver F] offered to pick up the shifts." Surveyor asked Lead Caregiver/Activities Director C if s/he was	N 158		

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interviewed regarding what she knew, witnessed and/or provided a written statement. Lead Caregiver/Activities Director C stated, "I was never interviewed or asked to write a statement. No one asked me for details."

On 02/18/2025 at 2:51 PM, Surveyors sent the following email to Executive Director A, "We've received multiple allegations about [Caregiver F] neglecting residents, not providing cares, leaving residents soaked in urine, not emptying catheter bags and missing narcotics when [Caregiver F] works. We've been told by several sources that you have been made aware of these allegations several weeks ago." Surveyors also questioned Executive Director A about Resident 3's allegation regarding Caregiver F. Surveyors asked Executive Director A to provide any investigation and/or documentation into the alleged allegation(s).
On 02/18/2025 at 4:30 PM, Executive Director A stated, "Yes, I actually just terminated [Caregiver F] this morning after it was reported [s/he] didn't complete assigned cares once again. I've attached the documentation I have for you here. Please let me know if you need anything further."

On 02/18/2025, Surveyors noted the provider's documentation included the following:

*A Grievance Resolution Form dated 02/04/2025 written by Resident 3, which indicated, "On 02/03/2025 at approximately 8:30 PM, I rang to be toileted. It took over an hour and a half and two phone calls to the main number. I laid in a totally wet bed and night gown. When [Caregiver F] came in [s/he] was rough, took sheets off and left me lying on the plastic mattress cover." The form indicated Executive Director A investigated and resolved the grievance on 02/04/2025 and

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N 158	Continued From page 10 indicated, "Disciplinary action with staff. Staff states resident educated [her/him] on why not to move too quickly while transferring. Staff states s/he did apologize in the moment and immediately moved slower. Resident did verify this. All parties agreed resolution satisfactory." *A Counseling/Disciplinary Notice for Caregiver F dated 02/04/2025 indicated, "[Caregiver F] has repeatedly failed to secure narcotics despite coaching and counseling from Executive Director on 02/01 and 02/02. Additionally, [Caregiver F] was observed speaking to a resident in a manner that is not conducive with the culture of our community, i.e. raising [her/his] voice. One resident complained [Caregiver F] moved too quickly during a transfer, resulting in said resident feeling unsafe. [Caregiver F] was also observed allowing a call light to ring in excess of 15 minutes, resulting in a resident's needs not being met. Corrective action: [Caregiver F] understands that all narcotics must be secured at all times, [Caregiver F] was educated on the narcotic count process and understands why this is so important. [Caregiver F] has been educated on appropriate approach to all residents, especially those with memory-care diagnosis. [Caregiver F] was educated on the importance of slowing down and moving at a pace that promotes safety for all residents. [Caregiver F] was educated on the expectation that all call lights are to be answered within 15 minutes. [Caregiver F] understands that this behavior will not be tolerated. Should narcotics be found to be unsecured again, or residents/staff report complaints [Caregiver F] is not behaving in a manner that promotes a culture of inclusion and safety, leadership will pursue further disciplinary action, up to and including termination. As a result of [Caregiver F's] actions, leadership will be	N 158		

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providing further medication training to [Caregiver F] on 02/05, 02/08, and 02/09. Moving forward, [Caregiver F] is only permitted to work as a Med Tech on NOC shifts until leadership determines [Caregiver F] is ready to take on more responsibility. [Caregiver F] may continue to pick up AM/PM shifts, however, may only act as a caregiver at this time."

*A timeline of events regarding allegations against Caregiver F with Executive Director A's handwritten notes next to dates in February 2025, indicated:
~02/04/2025- Resident 3's Grievance
~02/05/2025- Positive feedback from staff
~02/06/2025- Med Training provided
~02/07/2025- Teachable moment completed with Caregiver F regarding the importance of positive interactions with staff and residents. Night shift pop-in completed rounds together. Positive feedback post shift. Verified with camera rounds were completed.
~02/10/2025- Teachable moment completed with Caregiver F regarding expectations of night shift cares.
~02/11/2025- Night pop-in all residents dry and happy. No concerns
~02/16/2025- Negative feedback. No night cares completed. Appears cleaning may not have been done.

*A Termination form for Caregiver F, dated and signed by Executive Director A on 02/18/2025 indicated, Caregiver F was termed and her/his last day worked was on 02/18/2025.

On 02/18/2025 at 4:45 PM, Surveyors ask Executive Director A if s/he had any additional information. Executive Director A verified s/he provided all documented information to

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N 158	Continued From page 12 Surveyors, and no further documentation was available. Executive Director A stated, "That's correct. I had multiple conversations with [Caregiver F] over the very short period time [s/he] worked with us ...After [Resident 3] turned in the grievance, we made sure that [Caregiver F] had additional supervision while working so that I could verify [s/he] was not neglecting anyone. [Caregiver F] was provided with additional training by many members of our team, and [s/he] still could not grasp what the job entailed. That is why I made the decision to term [her/him] today, as I do not feel [s/he] is capable of learning the job...And let me be clear-no narcotics were ever discovered to be missing. In every instance that staff claimed narc count was off, we were able to locate them immediately, i.e; a staff forgot to sign the med out and PCC (Point Click Care) verified that, or a card was placed in the wrong spot in the narc drawer and staff was overlooking it." Surveyors noted the documentation did not include: ~Documentation of an interview with Resident 3 to obtain more information about the allegations and any effects they may have had on Resident 3's skin condition or psychosocial well-being ~Documentation to show Resident 3's call light logs were reviewed or if an effort was made to determine if the call light was functioning and in reach. ~Documentation to show other residents' call light logs were reviewed to establish if long wait times occurred. ~Documentation of interviews with Caregiver B, C, D and E who witnessed and informed Executive Director A of potential misconduct by Caregiver F ~Documentation of interviews with other staff to determine if they witnessed or had information	N 158		

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N 158	Continued From page 13 about the allegations ~Documentation of interviews with other residents to determine if their needs were met, if they received their medications as prescribed or if they had experienced similar incidents. ~Any effects the incident(s) may have had on other residents' skin condition or psychosocial well-being ~Documentation to show medication administration records and narcotic counts were reviewed for Resident 2 and Resident 8 to determine if any medications errors occurred or possible misappropriation ~The conclusion of the investigation or a determination if a MIR (Misconduct Incident Report) should be submitted to the Department ~Evidence Caregiver F was retrained on residents' rights to be free from abuse or neglect. On 02/18/2025, Surveyors reviewed Caregiver F's time sheets. The time sheets revealed Caregiver F worked the following dates and times: *02/03/2025: 6:48 PM-12:45 AM *02/05/2025: 10:55 PM-7:28 AM *02/06/2025: 4:39 PM- 7:53 AM *02/07/2025: 9:59 PM- 8:04 AM *02/10/2025: 6:51 AM-11:10 AM and 11:00 PM-11:11 AM *02/12/2025: 12:30 AM-7:24 AM *02/13/2025: 7:06 AM-2:03 PM *02/14/2025: 8:00 AM-2:02 PM *02/15/2025: 6:53 PM-7:03 AM *02/16/2025: 3:55 PM-8:32 PM and 10:59 PM-7:05 AM *02/17/2025: 10:54 PM-7:07 AM On 02/17/2025, staff verified the facility schedules one caregiver during the night shift from 11 PM-7 AM. Surveyor reviewed the February 2025 staff	N 158		

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N 158	Continued From page 14 schedule and noted Caregiver F worked alone on 02/03/2025 from 6:48 PM-12:45 AM and during the night shift on the following days 02/05/2025, 02/06/2025, 02/07/2025, 02/10/2025, 02/12/2025, 02/15/2025, 02/16/2025 and 02/17/2025. The provider did not conduct or document a thorough investigation into the incident with Resident 3 or the allegations made by multiple facility staff to rule out caregiver misconduct and to determine if the incident(s) were reportable. The provider did not take immediate steps to protect all residents from subsequent incidents of misconduct when Caregiver F continued to work alone, providing direct resident care until the morning of 02/18/2025 (the day after Surveyors' onsite visit), when Executive Director A terminated his/her employment. Example 2 On 02/17/2025, Surveyor reviewed Resident 1's medical record. Resident 1 was admitted to the facility on 02/16/2019 with diagnoses to include Multiple Sclerosis. Resident 1 was his/her own person and able to make his/her needs known. Resident 1's ISP dated 08/14/2024, indicated the resident has a call light in room, a motorized wheelchair for mobility and requires assistance with dressing, bathing and toileting. Additionally, the ISP indicated Resident 1 was incontinent of bladder and bowel, required the assistance of two staff and a mechanical lift for transfers, and noted, "Resident requires 2-3 hour checks for safety/incontinence/catheter care ...Resident will also ring as needed when needing assist during the night." On 02/17/2025 at 12:50 PM, Surveyor interviewed Resident 1 regarding the care and	N 158		

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N 158	Continued From page 15	N 158		

treatment s/he receives at the facility. Resident 1 recalled an incident in February where s/he was left in a soiled brief overnight after notifying staff that s/he needed to be changed. Resident 1 began crying and stated, "some of the people they hire are not cut out for this line of work ...you don't even have to learn their names because they're not here long enough for you to learn them."

On 02/25/2025 at 2:15 PM, Surveyor interviewed Caregiver D. S/he recalled an incident where Resident 1 requested peri care in the evening following a bowel movement and was not provided cares until the following day. S/he said Caregiver U notified him/her the morning of 02/04/2025 that Resident 1 requested peri care the night before. Caregiver D and Caregiver U provided peri care to Resident 1 following breakfast at approximately 10:00 AM.

Following Surveyors request on 02/18/2025, Executive Director (ED) A provided email correspondence with Compliance Partner (CP) T regarding the aforementioned incident which contained the following:

-- 02/04/2025: ED A sent CP T email which read in part, " ...investigating a complaint today ... [Resident 1] stated [s/he] pulled ...call light at 8pm ...Caregiver, [Office Manager G] told [him/her] [s/he] was grabbing someone to help and would be back. Resident states [s/he] never came back ...Resident does not call again until 7am, informs staff [Caregiver U] and [Caregiver D], [s/he] needs a change, staff says they'll come back and don't return until 10am. The resident did inform [his/her] care team of this and we are worried there will be a complaint with the state for obvious reasons ...We met with the resident this afternoon

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N 158	Continued From page 16 ...[S/he] stated [s/he] feels reassured and safe at this time ...Meeting with staff is a whole other story. They all have some excuse as to why they didn't change [him/her]." -- 02/05/2025: CP T sent email response to ED A which read in part, " ...yes, I will investigate this one for sure ..." -- 02/05/2025: ED A responded to CP T email which read in part, " ...We asked if NOC checked on [him/her], but [s/he] couldn't recall. The expectation is 'frequent checks.'" -- 02/05/2025: CP T responded to ED A email which read in part, " ...What day did the resident state this happened on?..." -- 02/05/2025: ED A responded to CP T email which read in part, " ...[S/he] first rang on 02/03 around 8pm and rang again on 02/04 around 7am ..." -- 02/12/2025: CP T responded to ED A email which read in part, " ...Is the resident alert and oriented?..." -- 02/12/2025: ED A responded to CP T email which read in part, " ...[S/he] is, we did advise [him/her] you may be contacting [him/her] ..." On 02/20/2025, Surveyor emailed CP T and requested all materials regarding the investigation be provided within one business day. As of 02/24/2025, Surveyor had not received a response or the requested documents. On 02/24/2025, Surveyor interviewed CP T. S/he acknowledged receipt of email records request from 02/20/2025. S/he verified that s/he had not spoken to the alleged victim as of 02/24/2025, 20 days after being notified of allegations. On 02/24/2025, CP T emailed Surveyor which read in part, " ...I am gathering the information and having it reviewed and will get it to you as	N 158		

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N 158	Continued From page 17 soon as possible ..." On 02/26/2025, CP T emailed Surveyor which read in part, " ...apologies for getting this back to you so late but I have attached the information I have in regards to the investigation ..." The email contained a document titled "Cranberry Court - PEN-2025- 1198" which outlined the investigation completed. The document read in part, " ...Executive Summary: ...After review of labor reports, schedules and interview with staff and [Resident 1] this allegation is partially substantiated. Corrective action to be implemented to ensure a process is in place to meet the needs of all residents in a timely manner ..." The investigation included one attempt to contact Resident 1 on 02/20/2025, 17 days after the incident occurred and an interview with Resident 1 on 02/24/2025, 21 days after the incident occurred. Surveyor noted the documentation did not include: -- Documentation to show Resident 1's call light logs were reviewed or if an effort was made to determine if the call light was functioning and in reach. -- Documentation to show other residents were interviewed and/or their call light logs were reviewed to establish if they experienced long wait times or had concerns about care overnight on 02/03 or other times. -- Documentation of interviews with Caregiver U and Caregiver D, the two caregivers who were working during the alleged incident. -- Documentation of specifics regarding the "corrective action" implemented following	N 158		

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N 158	Continued From page 18 investigation.	N 158		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interviews the provider did not ensure each resident the right to receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 6 did not receive all prescribed medication, including scheduled doses of Warfarin Sodium 4 mg (an anticoagulant) for five consecutive days from 11/28/2025 through 12/02/2025, which resulted in the resident's INR (international normalized ratio) level to be out of range Findings include: On 12/04/2024, 01/13/2025 and 01/15/2025. The Department received concerns regarding medication administration. According to www.drugs.com/warfarin.html, updated 02/24/2025, "Warfarin is an anticoagulant (blood thinner). Warfarin reduces the formation of blood clots. Warfarin is used to treat or prevent blood clots in veins or arteries, which can reduce the risk of stroke, heart attack,	N 352		

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N 352	Continued From page 19 or other serious conditions..." According to thrombosis.org/2020/11/guide-inr-levels, updated 04/25/2024, "INR is measured with a blood test...This test measures how long it takes for your blood to clot. If your INR is too low, you could be at risk for a blood clot. If it's too high, you could experience bleeding." On 02/17/2025, Surveyor reviewed Resident 6's closed record which indicated, the resident was admitted to the facility on 03/10/2023 with diagnosis to include diabetes and heart failure. Additionally, the facility managed and administered all of Resident 6's medications. A physician's order dated 11/26/2024 for Resident 6 indicated, "Warfarin Sodium Oral tablet 4 mg. Give 2 tablet by mouth at bedtime for A-fib (Atrial fibrillation)." An incident report for Resident 6 dated 12/04/2024 indicated, "[Resident 6] missed doses of Warfarin on 11/28, 11/29, 11/30, 12/01 and 12/02. No physical adverse reactions noted. [Resident 6's] INR was off. New dose ordered for correction on 12/03. Medication error was discovered and reported by WD (Wellness Director). WD notified physician and guardian on 12/03 around 1130. ED (Executive Director) was notified 12/03 around 1200. ED launched investigation. WD obtained new orders and delivery of Warfarin from pharmacy. [Resident 6] received medication as ordered on 12/03. Staff was educated." Resident 6's EMARs (electronic medication administration records) for the month of November 2024 and December 2024 were	N 352		

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reviewed. Surveyor noted the EMARs contained staff initials with a number "7" in the entry box for the Warfarin Medication from 11/28/2024 through 12/02/2024. Surveyor noted the chart code for the number "7" was "Other/See Nurse Notes."

On 02/17/2025, Surveyor reviewed Resident 6's Progress notes for November 2024 and December 2024 and noted the following:

~11/28/2024- "Warfarin Sodium Oral tablet 4 mg. Give 2 tablet by month at bedtime for A-fib. Medication unavailable. Pharmacy closed today for the holiday." (Entry was documented by Former Caregiver M)
~11/29/2024- "Warfarin Sodium Oral tablet 4 mg. Give 2 tablet by month at bedtime for A-fib. Medication unavailable. Pharmacy closed." (Entry was documented by Former Caregiver M)
~11/30/2024- "Warfarin Sodium Oral tablet 4 mg. Give 2 tablet by month at bedtime for A-fib. Call daily drug (the pharmacy) for a refill." (Entry was documented by Former Caregiver J)
~12/01/2024- "Warfarin Sodium Oral tablet 4 mg. Give 2 tablet by month at bedtime for A-fib. Still haven't received medicine from daily drug." (Entry was documented by Former Caregiver J)
~12/02/2024- "Warfarin Sodium Oral tablet 4 mg. Give 2 tablet by month at bedtime for A-fib. Not in cart." (Entry was documented by Former Caregiver N)

A pharmacy delivery sheet dated 11/27/2024 indicated, 28 tablets of Warfarin 2 mg tablets were delivered to the facility. Caregiver L signed the pharmacy delivery sheet on 11/27/2024 indicating s/he accepted and received the medication.

On 02/17/2025 at approximately 11:00 AM,

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N 352	Continued From page 21 Surveyor requested the facility's documentation from BOM (Business Office Manager)-G into the above medication error for Resident 6. BOM-G verified Resident 6 did not receive the Warfarin medication for 5 days and staff were disciplined and/or termed following this incident. Surveyor reviewed the facility's documentation into the medication error for Resident 6. The documentation included Resident 6's November 2024 and December 2024 EMARs, a pharmacy delivery sheet, staff schedules and disciplines. The documentation also included an email from former WD-K to ED-A and BOM-G. The email was dated 12/03/2024 and indicated, "I got a call from staff last night about [Resident 6] not having [his/her] Warfarin, apparently, [s/he] hasn't had it since the 28th!!!!!!! NO ONE told me this or called pharmacy!!!...[Caregiver L] did sign for that...I spoke with [Caregiver L] already and educated [her/him] on opening the bag, looking at the medication and pill count and then signing ([Caregiver L] did not open the bag to check)...I am waiting on [Former Caregiver J] to call me back as well because [s/he] signed it out as a "7" as well but never notified me or pharmacy. [Resident 6's] family and Guardian are very upset over this...I did put out different sheets last night for missing meds/follow-up to meds that I think will help...I formulated a plan yesterday to move forward and help get rid of the "7's..." Surveyor reviewed staff disciplinary notices dated 12/04/2024 regarding Resident 6's medication error and the following was noted: ~ "[Caregiver L] signed for the medication on 11/27 and failed to appropriately check the medication in. This resulted in a resident missing several doses of a crucial medication." ~ "[Former Caregiver M] signed out the medication on 11/28 and 11/29 stating "Medication unavailable. "Pharmacy closed for	N 352		

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N 352	Continued From page 22 holiday and medication unavailable" without notifying leadership or taking further action to ensure the drug was in house and administered. The drug in question was delivered on 11/27. [Former Caregiver M] neglected to find and administer the medication. Additionally, the pharmacy was OPEN on 11/29." ~ "[Former Caregiver J] signed out a medication on 12/01 and 12/02 stating "call daily for a refill' and "still haven't received from daily drug" without notifying leadership or taking further action to ensure the drug was in house and administered. The drug in question was delivered on 11/27. [Former Caregiver J] neglected to find and administer that medication." ***Surveyor noted Former Caregiver M and J were re-educated on what to do if a medication was not located, but Former Caregiver N was not re-educated when s/he documented the Warfarin medication was "Not in cart." Also, no documentation was provided indicating additional training was provided to other medication technicians that were not directly involved in this incident. In conclusion, Resident 6 did not receive the Warfarin medication as ordered resulting in the resident's INR being out of range.	N 352		
N 425	83.38(1)(a) Personal care. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the	N 425		

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N 425	Continued From page 23 residents in all of the following areas: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure that personal care services were provided to meet the needs of Resident 13 and Resident 1. Resident 13 did not receive his/her shower once per week and had a total of 2 documented showers during approximately 4 month period from June 2024 to October 7th 2024. Resident 1's catheter was observed full of urine, three times, during a 2 hour period on 02/17/2025. Findings include: The provider is licensed to care for up to 22 residents who may be advanced aged, terminally ill, physically disabled, irreversible dementia/Alzheimer's and/or developmentally disabled. On 09/05/2024, 01/10/2025, 01/15/2025, and 02/05/2025, the Department received complaints regarding care concerns. Resident 13	N 425		

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N 425	Continued From page 24 On 02/24/2025 at 1:00 PM, Surveyor interviewed Guardian R. S/he stated s/he had concerns that Resident 13 was not receiving his/her showers. S/he stated Friend S would visit Resident 13 and had concerns that Resident 13 was not receiving adequate care. Guardian R spoke with Office Manager G on a "number of occasions" regarding concerns that Resident 13 was not receiving adequate personal cares including his/her showers. On 02/25/2025 at 1:47 PM, Surveyor interviewed Caregiver D. S/he recalled Resident 13 was to receive a shower weekly. S/he stated Resident 13, " ...did not get that. Maybe once a month if [s/he] allowed it ...a lot of people just left [him/her] alone due to [his/her] behaviors ...[s/he] would take off [his/her] clothes and poop on it ... [Resident 13] changed [his/her] clothes every other day ..." On 02/26/2025 at 4:40 PM, Surveyor interviewed Caregiver B. S/he said, " ...[s/he] had a hard time letting staff help [him/her] ...refused to let us help shower. S/he recalled a friend that would come and visit that would occasionally get Resident 13 to take a shower. Caregiver B was unaware of specific means to reapproach Resident 13's shower refusals. On 02/27/2025 at 4:15PM, Surveyor interviewed Friend S. S/he said s/he visited Resident 13 "once a month, a couple times I would go twice ...I would make surprise visits." S/he expressed concerns Resident 13 was not receiving adequate hygiene care. S/he described a visit where s/he found Resident 13's carpet, bed, and pants covered in feces. S/he stated it was "nasty ...not to my standards...it was horrible ...I know	N 425		

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N 425	Continued From page 25 [s/he] was stubborn, but that was their job ...every time I came there it was crappy." S/he stated that s/he would give Resident 13 a shower during each visit. Friend S said Resident 13 would refuse his/her shower initially, but "I would coach [him/her]" to get him/her in the shower. S/he recalled visiting Resident 13 approximately 1-2 times each month. On 02/17/2025 , Executive Director (ED) provided Resident 13's most recent Individualized Service Plan (ISP) dated 08/15/2024. The ISP identified Resident 13's need for physical assistance while bathing and "reminders" to change clothes daily. S/he was unable to make decisions independently and required additional "cueing" due to "impaired judgement." The document read in part, " ...staff to encourage appropriately ..." and " ...staff to encourage resident to wear clean clothes daily ..." The ISP did not identify specific strategies for refusals or give examples of effective or appropriate encouragement. Following Surveyor request, on 02/27/2025 ED A emailed Surveyor documents titled "[Resident 13]" and replied, " ...[Resident 13] more often than not refused [his/her] showers. [S/he] had a good friend who would come in and get [him/her] into the shower. When that occurred, we did not document it as the staff didn't complete the shower themselves ...[sic-all]" On 02/27/2025, Surveyor reviewed a form titled "[Resident 13]" which documented showers/baths and skin integrity checks. During the months of June, July, August, September, and October 1st through 7th 2024, Resident 13 received 2 documented baths/showers and 3 documented skin integrity checks.	N 425		

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Following request, on 02/25/2025 Surveyor received document titled "[Resident 13] EMR Report" regarding an Emergency Room visit on 08/31/2024. The document read in part:

" ...sent from [his/her] assisted living facility cranberry court for dysuria ...[S/he] is alert and oriented ...[S/he] does have significant hygienic issues it appears [s/he] has not been based [sic] or tendon to [sic] for several weeks ...Patient reports [s/he] was sent here because "I am difficult, they do not want to deal with me " ...Significantly poor hygiene ...Nurse attempted multiple times to call cranberry court with no avail. We are unable to contact cranberry court to discuss patient's care ...There is some concern that patient was not being tended to appropriately due to [his/her] personality. Here in the ER [s/he] was appropriate ...Final diagnosis ...Poor hygiene ...[sic-all]"

Following Surveyor request, on 02/17/2025, ED A provided Surveyor with a document titled, "Progress Notes *NEW*" which read in part, "Resident was found expired in room around 0830 on 10/07/24."

Resident 1

On 02/17/25 at 10:30 AM Surveyor interviewed Resident 1. Resident 1 was seated in a recliner. Resident 1's catheter bag was lying in a gray wash basin on the floor next to the recliner and Surveyor observed it was full with urine going from the bag back into the catheter tubing approximately 12 inches. Surveyor asked Resident 1 how often this catheter bag is emptied. Resident 1 indicated staff are to empty it when it is full and that an Inclusa (managed care organization) Home Health Aide also comes

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in daily in the afternoon to empty it. Surveyor asked Resident 1 if any facility staff checked it today. Resident 1 indicated Caregiver's B and C were in about 8:30 AM this morning, saw it and said it was full but didn't empty it. Resident 1 indicated no one has been back to empty it.

On 02/17/25 at 11:40 AM Surveyor went back to Resident 1's room and found the catheter bag still in the gray wash tub and full of urine. Resident 1 confirmed no facility staff emptied the catheter bag since it was observed by Caregiver's B and D this morning.

On 02/17/2025 at 12:50 PM, Surveyor went into Resident 1's room and observed the catheter bag in the grey wash tub still full of urine. Resident 1 was unsure if staff had recently been in to empty his/her catheter bag but stated staff knew it needed to be emptied that morning.

On 02/17/2025 at 1:30 PM, Surveyor asked Caregiver A if s/he had recently checked on Resident 1's catheter. S/he stated, "I haven't checked on [him/her] yet ...we were both in there for breakfast ...I am fairly certain (Caregiver D) checked (catheter)"

On 02/17/2025 at 2:10 PM, Surveyor and Caregiver A entered Resident 1's room. Surveyor observed Resident 1's catheter bag in the grey wash tub partially full of urine. Caregiver A recalled observing Resident 1's catheter bag full at approximately 8:30 AM, but did not empty the bag at that time. Surveyor asked Resident 1 if s/he recalled who emptied his/her catheter bag. S/he responded, "[Caregiver A] just emptied it" and attested that nobody else had emptied the catheter bag earlier in the day.

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N 425	Continued From page 28 Following Surveyor request, on 02/17/2025 Executive Director A provided Resident 1's most recent ISP dated 08/14/2024. Resident 1 was admitted to the facility on 02/16/2019 and is able to make his/her own decisions. The ISP identified Resident 1's need for assistance from staff regarding his/her bowel and bladder incontinence. The ISP identified Resident 1's indwelling catheter and the need to provide care every shift which included catheter cleaning and emptying of catheter drainage bag. The ISP read in part, " ...Resident requires 2-3 hour checks for safety/incontinence/catheter care ..." In Summary: Resident 13 relied on staff assistance for showers at least once weekly, however during a 4 month period only 2 showers were documented. His/her ISP identified the tendency to refuse cares but did not include specific strategies to re-approach and encourage showers. Caregivers acknowledged Resident 13's lack of hygiene and tendency to decline showers, but were unaware of specific means to reapproach. Friend S visited Resident 13 1-2 times per month and was successful in providing showers. Resident 13 was transported to the emergency room on 08/31/2024 and was observed to have "poor hygiene". Resident 13 passed away in his/her room 37 days later. The cause of death was not documented in the resident record. Resident 1 did not receive necessary assistance with emptying his/her catheter bag. On 02/17/2025, Resident 1's catheter bag was observed full of urine, three times, during a 2 hour period. Caregivers observed the catheter bag was full as early as 8:30 AM, but did not empty it until approximately 4.5 hours later.	N 425		

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N 427	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Leisure time activities. The CBRF shall provide 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. This Rule is not met as evidenced by: Based on observation and staff and residents interviews the provider did not ensure an activity schedule was posted and daily activities were provided to meet resident needs having the potential to affect all 18 residents. Findings include: During a tour of the facility on 02/17/2025 at approximately 9:45 AM Surveyor noted there was no activity schedule posted. A bulletin board in the common area next to the dining room had a sign saying "Please enjoy some self-directed activities while we recover from COVID." A supply cabinet below contained crayons, art supplies, and word puzzles. On 02/17/2025 at 12:50 PM, Surveyor interviewed Resident 1. S/he said there have been no activities since "Christmas." S/he said, "If	N 427		

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N 427	Continued From page 30 there were ...I would have a reason to go out and mingle." On 02/17/2025 at 1:41 PM, Surveyor interviewed Resident 7. S/he said s/he had been coordinating the activities for "three years" and it "was rough." S/he stated, "in all the time, three years, they gave me a Starbucks card for 15 dollars and they gave me a pizza hut thing for one pizza." On 02/17/25 at 2:50 PM Surveyor spoke with CG (Caregiver) - B who confirmed there was no activity schedule posted and that the only activities currently being offered were self-directed activities. Observation by Surveyors throughout the day on 02/17/2025 from 09:00 AM to 3:00 PM showed no activities provided to residents. At approximately 3 PM a group of 4 residents went to the dining room to play a game of cards of their own accord. In an interview with Surveyor on 02/18/2025 at 3:30 PM, AD (Activity Director) - C confirmed group activities and individual activities were not provided since December as the facility had a COVID outbreak. AD - C said s/he had to work the floor and could not provide activities and provide cares. AD - C confirmed the facility was no longer in outbreak status, however activities had not resumed.	N 427		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or	N 432		

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N 432	Continued From page 31 arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure the provision of medication administration appropriate to residents' needs. The provider did not ensure Resident 8 received the supervision s/he needed during medication administration. Findings include: The provider is licensed to care for up to 22 residents who may be advanced aged, terminally ill, physically disabled, irreversible dementia/Alzheimer's and/or developmentally disabled. On 01/13/2025 and 01/15/2025, the department received complaints alleging concerns with medication administration. On 02/17/2025 at 9:30 AM, Surveyor interviewed Resident 8 and Healthcare Power of Attorney (POA) Q. Resident 8 stated, "the night before I never slept at all ...my medications should come 10-10:30." Resident 8 said the caregiver working that evening, "brought me the pills and ...set them in a cup." S/he recalled the caregiver asking him/her that if s/he left them for Resident 8 that s/he would promise to take them. Resident 8	N 432		

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N 432	Continued From page 32 stated, "I didn't want to be without them" and said s/he would take the medication. POA Q pointed to the ground next to Resident 8's recliner and Surveyor observed a white pill lying on the floor with "A10" engraved on top. POA Q picked up the pill from the floor, showed it to Resident 8 and asked him/her if s/he could identify the pill. Resident 8 was unable to identify the pill and went on to say s/he has difficulty with his/her vision. On 02/17/2025 at 9:50 AM, Caregiver B returned to Resident 8's room and stated that the pill found on his/her floor was "atorvastatin" and that Resident 8 receives that medication every day in the evening. Record Review On 02/17/2025, Manager G provided Surveyor with Resident 8's current Individualized Service Plan (ISP), Medication Administration Records (MARs) for December, January, and February and current physician orders. On 02/17/2025, Surveyor reviewed Resident 8's ISP, dated 09/02/2024. The document identified the need for reminders due to Resident 8's "occasional forgetfulness" and that s/he relied on staff to administer his/her medications. On 02/17/2025, Surveyor reviewed Resident 8's current physician orders which included, " ...ATORVASTATIN 10 MG TABLET TAKE ONE TABLET BY MOUTH EVERY DAY AT 8PM FOR HLD ..."	N 432		
N 439	83.39(1) Infection control program. The licensee shall establish and follow an	N 439		

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N 439	Continued From page 33 infection control program based on current standards of practice to prevent the development and transmission of communicable disease and infection. This Rule is not met as evidenced by: Based on interviews and record review, the provider did not establish and follow an infection control program based on current standards of practice to prevent the development and transmission of communicable disease and infection. During a COVID-19 outbreak beginning on 01/03/2025, the provider did not ensure: ~The local public health department was notified immediately of the COVID-19 outbreak ~The staff line list was complete to include well dates to ensure staff were not returning to work prior to the recommended time frame ~Staff that tested positive for COVID-19 were removed from the schedule until they were past their full infectious period ~Residents' legal representatives were immediately notified when residents had confirmed COVID-19 infection Four (4) of 18 residents contracted the COVID-19 virus. Cranberry Court II has had a regular Class CNA (non-ambulatory) CBRF license since 08/01/2016 for the capacity of 22 residents who are terminally ill, physically disabled, advanced aged, developmentally disabled, emotionally disturbed/mental illness, and/or have irreversible dementia/Alzheimer's disease. The facility is	N 439		

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N 439	Continued From page 34 located on the same grounds as Cranberry Court I (a sister facility with a paved walkway located between the two facilities) and staff are shared between the two buildings. Findings include: On 01/10/2025, 01/13/2025 and 01/13/2025, the Department received concerns regarding infection control. Per Wis. Admin. Code § DHS 145.03 (11) and 155.01(6), community-based residential facilities (CBRFs) are defined as health care facilities. The facility's policy and procedure titled, "Coronavirus (COVID-19) revised on 01/18/2024 indicated, "It is the policy of the community to implement safe practices, preventive measures, and act in accordance with any specific state and federal regulations pertaining to communicable disease. DEFINITIONS: ..." Staff" include, but not limited to, direct care staff as well as persons not directly involved in patient care (e.g., clerical, dietary, environmental services, laundry, security, engineering and facility management, administrative, billing, consultants, vendors, and volunteers)...Reporting: An outbreak of 3 or more COVID cases needs to be reported to Health Department as a Respiratory Outbreak...Any staff that develop signs and symptoms of a respiratory infection while on-the-job will be asked to: Immediately stop work, put on a facemask, test for COVID-19 with an antigen test. Inform the community's Wellness Director and include information on individuals, equipment and locations the person came in contact with. Work Restrictions: All staff must adhere to CDC guidelines and local county health guidance when clearing positive/suspected personnel for return	N 439		

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to work...Will be removed from work if symptoms develop, or test is positive...A line list will be kept and completed for the community to use to keep track of the number of cases, weather staff or residents..."

OUTBREAK:

On 02/17/2025, BOM (Business Office Manager)-G provided Surveyor with documentation of the facility's COVID-19 outbreak, and Surveyor noted the following:

*On 01/02/2025, two staff tested positive for COVID-19 (Caregiver D and Lead Caregiver/Activities Director-C)
*On 01/03/2025, four residents tested positive (Residents 9, 10, 11 and 12) and one staff tested positive for COVID-19 (Caregiver B)
*On 01/04/2025, one additional staff tested positive (Dietary Director O)

PUBLIC HEALTH AND OUTBREAK LINE LIST:

The Departments website, Preventing and Controlling Respiratory Illness Outbreaks in Long-Term Care Facilities and Other Health Care Settings (Source: www.dhs.wisconsin.gov/respiratory/outbreak.htm) , last revised 12/30/2024, noted the following: "This webpage includes guidance for preventing and controlling acute respiratory illness outbreaks in Wisconsin long-term care facilities (LTCFs) and other health care settings. For the purposes of this guidance, LTCFs include skilled nursing facilities (SNFs), CBRFs, and residential care apartment complexes (RCACs)...Outbreak definitions and key terms: A suspected respiratory disease outbreak in LTCFs and other health care settings is defined as three or more residents

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and/or staff from the same unit with illness onsets within 72 hours of each other and who have pneumonia, acute respiratory illness, or laboratory-confirmed viral or bacterial infection (including influenza and COVID-19)...Outbreak reporting requirements in Wisconsin, confirmed or suspected outbreaks of any disease in health care facilities, including long-term care facilities, are a Category I Disease, meaning they shall be reported immediately by telephone to the patient's local health officer, or to the local health officer's designee, upon identification...Outbreak line lists: LTCFs are strongly encouraged to maintain and update a line list during an ARI (acute respiratory illness) outbreak to organize case information..."

On 02/17/2025, Surveyor reviewed an email sent from Executive Director A to the local public health department on 01/07/2025 indicating, "I wanted to inform you that Cranberry Court Assisted Living is currently experiencing a COVID outbreak. I have attached the staff and resident line list for you..." Surveyor noted on 01/03/2025 seven residents and/or staff had positive COVID-19 test results and the local health department was notified of the outbreak until 01/07/2025, four days later.

On 02/26/2025 at 3:45 PM, Surveyor interviewed Executive Director A, Surveyor asked when the local public health department was notified of the confirmed COVID-19 positive cases. Executive Director A verified the local health department was notified via email on 01/07/2025 of the COVID-19 positive cases for residents and staff.

On 02/17/2025, Surveyor reviewed the facility's COVID-19 outbreak line list for staff and the following was noted:
~01/02/2025- Caregiver D and Lead

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N 439	Continued From page 37 Caregiver/Activities Director-C tested positive for COVID-19 and had symptoms ~01/03/2025- Caregiver B tested positive for COVID-19 and had symptoms ~01/04/2025- Dietary Director O tested positive for COVID-19 and had symptoms ***Surveyor noted the staff line list contained the date of the positive test result, onset of symptoms, and when staff last worked, but none of the staffs' well dates were listed. The staff line list was not complete to include well dates to ensure staff were not returning to work prior to the recommended time frame. On 02/17/2025 at 1:50 PM, BOM-G verified to Surveyors the staff line list was up to date and complete, with no additional documentation to provide. RETURN TO WORK: The CDC Interim Guidance for Managing Healthcare Personnel (HCP) with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 (Source: www.cdc.gov/covid/hcp/infection-control/guidance-risk-assesment-hcp.htm), dated 03/18/2024, indicated, "Return to Work Criteria for HCP with SARS-CoV-2 Infection...HCP with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: At least 7 days have passed since symptoms first appeared if a negative viral test is obtained within 48 hours prior to work or 10 days if testing is not performed or if a positive test at day 5-7, and at least 24 hours have passed since last fever without the use of fever reducing medications, and symptoms have improved...HCP who were asymptomatic throughout their infection and are	N 439		

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not moderately to severely immunocompromised could return to work after the following criteria have been met: At least 7 days have passed since the date of their first positive viral test if a negative viral test is obtained within 48 hours prior to returning to work or 10 days if testing is not performed or if a positive test at day 5-7. Either a NNAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later...Test-based strategy HCP who are symptomatic could return to work after the following criteria are met: Resolution of fever without the use of fever-reducing medications, and Improvement in symptoms (e.g., cough, shortness of breath), and Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT. HCP who are not symptomatic could return to work after the following criteria are met: Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT."

On 02/26/2025, Surveyor reviewed staff time sheets for January 2025 and compared it to the staff test results during the same timeframe and noted the following:

~Caregiver D tested positive on 01/02/2025 and worked with residents on 01/04/2025, 01/06/2025, 01/07/2025, 01/10/2025 and 01/11/2025. No additional tests were documented for Caregiver D.
~Lead Caregiver/Activities Director-C tested positive on 01/02/2025 and worked with residents on 01/02/2025, 01/05/2025, 01/06/2025, 01/07/2025, 01/09/2025, 01/10/2025 and

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01/11/2025. No additional tests were documented for Lead Caregiver/Activities Director C.
~Caregiver B tested positive on 01/03/2025 and worked with residents on 01/03/2025, 01/04/2025 and 01/10/2025. No additional tests were documented for Caregiver B.
~Dietary Director O tested positive on 01/04/2025 and worked on 01/04/2025, 01/06/2025, 01/07/2025, 01/09/2025, 01/10/2025, 01/11/2025, 01/12/2025 and 01/13/2025. No additional tests were documented for Dietary Director O.

On 02/17/2025 at 2:00 PM, Surveyor interviewed Caregiver B regarding the COVID-19 outbreak in January 2025. Caregiver B verified the facility had an outbreak of COVID and a lot of staff were sick. Caregiver B stated, "When I came in for work on 01/04/2025, I tested myself for COVID twice. Both test results were positive. I had a fever, a sore throat and was very fatigued. I sent a text to [Executive Director A] with a picture of both my positive COVID test results...I was not removed from work...I continued to work with residents the entire shift because no staff was available..."

On 02/17/2025 at 12:40 PM, Surveyor interviewed Dietary Director O regarding the COVID-19 outbreak in January 2025. Dietary Director O confirmed s/he tested positive for COVID-19 and stated, "I tested positive at work. The direction was to seek our own coverage. I was off work a few days, but couldn't facilitate being out for multiple days because there was not enough staff."

On 02/17/2025 at 3:30 PM, Surveyor interviewed Lead Caregiver/Activities Director-C regarding the COVID-19 outbreak in January 2025. Lead

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N 439	Continued From page 40 Caregiver/Activities Director-C stated, "Sometime at the beginning of January 2025, I was really sick at work...I was okay when I came to work but as the shift went on, I started feeling ill. I had a fever; chills and I threw up in the garbage can in front of residents. I was working by myself because the other caregiver called in sick. I called [Executive Director A] and there was no answer. I called on-call and no-answer and then I tried to call everyone on the call list with no luck, so I had to work the shift sick." Lead Caregiver/Activities Director-C confirmed s/he tested positive for COVID-19 and stated, "When I tested positive for COVID a sent a picture to [Executive Director A] and was told I needed to find my own coverage." On 02/17/2025 at 1:41 PM, Surveyor interviewed Resident 7. Resident 7 stated, "Staff were sick at work and had no mask on. [Executive Director A] still let staff work, that is ridiculous cause then we get it. That is my biggest pet peeve...They should never have staff working when they are sick and they cannot wrap their finger around." On 02/18/2025 at 8:52 AM, Surveyor interviewed Resident 3. Resident 3 stated, "In early January 2025, staff were coming to work sick and they had COVID. I saw one staff so sick [s/he] was down on [her/his] knees, bent over throwing up. Another staff was working with a fever over a 100 degrees. Staff were mandated to work when sick. The sick staff were coughing and not properly masking...And some staff didn't even wear a mask." On 02/18/2025 at 7:00 AM, Surveyor interviewed Family Member I. Family Member I stated, "I was at the facility during the COVID outbreak in January 2025. Staff were working with COVID	N 439		

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N 439	Continued From page 41 and not wearing a mask. Staff told me they were forced to work sick and come into work sick." On 02/26/2025 at 3:45 PM, Executive Directive A verified no additional COVID testing was documented for the above staff. Surveyor asked Executive Director A about the facility's policy on return-to-work timeframes for staff that test positive for COVID-19. Executive Director A indicated, "I'm not sure, I didn't write the policy..." Surveyor then asked Executive Director A about allowing COVID positive staff to work before meeting the recommended isolation. Executive Director A confirmed the provider did not coordinate with their local health department regarding their intent to utilize COVID positive staff or submit a waiver request to DQA. NOTIFICATION On 02/17/2025, Surveyor reviewed the medical records for Residents 9, 11 and 12. The records indicated the following: ~Resident 9 was admitted to the facility 07/25/2024 and had a legal representative. The record indicated on 01/03/2025, Resident 9 tested positive for COVID-19 and the resident's PCP (Primary Care Provider) and care team was notified. No documentation was located indicating Resident 9's legal representative was notified immediately of the resident's COVID-19 infection. ~ Resident 11 was admitted to the facility 01/31/2024 and had a legal representative. The record indicated on 01/03/2025, Resident 11 tested positive for COVID-19 and the resident's PCP and care team was notified. No documentation was located indicating Resident 11's legal representative was notified immediately	N 439		

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N 439	Continued From page 42 of the resident's COVID-19 infection. ~ Resident 12 was admitted to the facility 11/13/2002 and had a legal representative. The record indicated on 01/03/2025, Resident 12 tested positive for COVID-19, and the resident's PCP and care team was notified. No documentation was located indicating Resident 12's legal representative was notified immediately of the resident's COVID-19 infection. On 02/26/2025 at 3:45 PM, Surveyor interviewed Executive Director A requesting evidence Residents' 9, 11 and 12 legal representative(s) were notified immediately of their confirmed COVID infection. Executive Director A verified no documentation was located in the above Residents' records and stated, "[BOM-G] was in charge of notifying legal representatives but failed to do it. After I became of aware of this I counseled [her/him] right away."	N 439		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation and interview, the provider did not keep all rooms free from odors. Findings Include: The provider is licensed to care for up to 22 residents who may be advanced aged, terminally ill, physically disabled, irreversible dementia/Alzheimer's and/or developmentally disabled.	N 489		

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N 489	Continued From page 43 On 01/13/2025, the Department received a complaint regarding laundry concerns. On 02/17/2025, Surveyors conducted an onsite visit to the facility. At 11:40 AM, Surveyor observed a strong odor which resembled urine and feces while in a common space hallway. Surveyor was wearing a surgical mask at the time. The odor appeared to originate from Resident 7's room. On 02/17/2025 at 11:40 AM, Surveyor entered Resident 7's room and observed the following: -- A pervasive odor which resembled urine and feces. -- Dark colored stains on the carpet next to Resident 7's bed. A plastic matt was laying on the floor which partially covered the stains. -- One white sheet folded in half laying on the center of the bed, on top of the fitted sheet. The white sheet contained multiple areas of dried yellow and brown colored stains. -- Dark red colored fitted sheet on the mattress covered in crumbs. -- Three pillows laying on the head of the bed. Two pillows were partially covered with pillowcases. All pillowcases contained yellow and brown colored stains. Two exposed pillows contained multiple yellow and brown colored stains. -- Items on Resident 7's nightstand were covered in yellow and brown colored stains including a TV remote, water bottle, and medical devices. -- A wheelchair with a brown stain on the seat approximately 6 inches long resembling dried feces. On 02/17/2025 at 11:45 AM, Surveyor interviewed Caregiver D in Resident 7's room. S/he attributed	N 489		

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the odor in the hallway and Resident 7's room to urine and feces and said the smell had persisted for two months. At 11:48 AM, Surveyor observed Caregiver D removing the soiled white sheet off of the bed. Surveyor observed dry yellow and brown colored stains on the fitted sheet, pillowcases, and pillows which remained on Resident 7's bed. Caregiver D stated the room is cleaned weekly, but "this room needs to be done every day ...housekeeping wise."

0n 02/13/2025 at 1:18 PM, Surveyor interviewed Housekeeper P. S/he provided Surveyor with the housekeeping schedule and said that each resident room is cleaned weekly. S/he described daily "room checks" where s/he observes rooms and compiles a list of tasks that need to be completed by caregivers within four hours.

On 02/26/2025 at 4:40 PM, Surveyor interviewed Caregiver B who said Resident 7's, "mattress is bad ...when [s/he] does sit up to pee nine out of ten times it is getting on the carpet ...(it is) getting gross ...(we) put a mat down. Now the mat just gets sticky and disgusting ...housekeeping has been notified of condition but it never gets done ..."

On 03/03/2025, Surveyor reviewed a document titled, "Housekeeping Schedule." The document listed Resident 7's room to be cleaned weekly and "spot checked" daily. The document also contained a checklist of "Room cleaning" tasks to be completed daily which included, " ...Wipe down all surfaces in bedroom and bathroom ..."

On 03/03/2025, Surveyor reviewed Resident 7's Individualized Service Plan (ISP) which indicated s/he was dependent on staff for housekeeping needs which included, " ...Empty garbage every

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N 489	Continued From page 45 shift. Daily housekeeping to prevent clutter. Daily bedmaking ..." Resident 7 also required assistance with emptying his/her urinal and "brief clean up." On 02/17/2025 at 1:41 PM, Surveyor interviewed Resident 7. S/he stated, "They always are angry like they are mad at the world ...they get mad at me because I cannot make it to the bathroom. A couple time they have had to clean me up."	N 489		
N 502	83.46(1)(a) Comfortable and safe temperatures A CBRF shall maintain comfortable and safe temperatures. The CBRF shall provide tempered air at all times to eliminate cold air drafts. The heating system shall be capable of maintaining temperatures of 74º F. in areas occupied by residents. This Rule is not met as evidenced by: Based on observations and interviews, the provider did not maintain comfortable temperatures. The heating system did not maintain temperatures of 74 degrees F (Fahrenheit) in areas occupied by Resident 2 and 3. On 02/17/2025 during the survey visit, Resident 3's room temperature measured 63 degrees F and Resident 2's room temperature measured 65 degrees F. Findings include:	N 502		

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N 502	Continued From page 46 On 01/10/2025, 01/13/2025 and 01/15/2025, the Department received concerns regarding the heat not working and uncomfortable temperatures. On 02/17/2025 at 9:45 AM, Surveyor toured the facility with Caregiver D. Surveyor and Caregiver D checked Resident 3's room temperature. Surveyor entered Resident 3's room and noted the room felt very cold. Surveyor observed the wall thermostat in Resident 3's room to read 63 degrees F. Surveyor and Caregiver D located two digital thermometers within the room. One located on top of the microwave and a second located on Resident 3's bed side table, both digital thermometers measured 64 degrees F. Caregiver D confirmed Resident 3's room was cold and the wall thermostat temperature reading was 63 degrees F. Caregiver D stated, "[Resident 3's] room is always cold. We've been having issues with [Resident 3's] heat not working for several weeks. I know the police were called last month to do a welfare check for [Resident 3] because [her/his] room was cold." Caregiver D then turned the heat up to 74 degrees F on Resident 3's wall thermostat, but the temperature stayed at 63 degrees F. Caregiver D stated ,"Certain rooms control the heat for the whole hallway and some rooms have a lock box and staff don't have a key to adjust the temperature...A company was here to fix the boiler last month, but it's still cold in some rooms, especially [Resident 3's] bedroom because [her/his] room is located at the end of the hallway." Caregiver D and Surveyor then observed Resident 2's room, which was located at the opposite end of the hallway. Surveyor entered Resident 2's room and noted the room felt cold. Surveyor observed the wall thermostat in Resident 2's room to read 65 degrees F. Caregiver D confirmed the temperature reading	N 502		

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and stated, "My nose is cold in this room." During the tour Surveyor observed the common area to be much warmer than Resident 2's and Resident 3's room.

On 02/17/2025 at approximately 10:40 AM, Surveyor returned to checked the temperature in Resident 2's room. Resident 2 was lying in bed under the covers. Surveyor noted it to be very cold in the room. Resident 2 did not respond to Surveyor's question about temperatures. Observation of the thermostat showed it was set at 78 degrees F but the actual temperature on the thermostat was 66 degrees F.

On 02/17/2025 at approximately 11:00 AM, Surveyor and Caregiver B returned to Resident 3's room an hour and fifteen minutes after the thermostat was adjusted to 74 degrees F by Caregiver D. Surveyor observed the wall thermostat in Resident 3's room to be 63 degrees F. Caregiver B acknowledged the thermostat read 63 degrees F and stated, "[Resident 3] complains often [her/his] room is cold...For some reason the bedrooms located at the end of the hallways are colder than others. [Resident 3's] room is cold and I'm wearing a long sleeve shirt...I don't think [Resident 3's] thermostat works in [her/his] room."

On 02/17/2025 at 9:30 AM, Surveyor interviewed Power of Attorney (POA) Q. S/he attested to previous statements that Resident 3 was unable to get temperature in his/her room over 63 degrees.

During an interview on 02/18/2025 beginning at 8:52 AM, Resident 3 told Surveyor it was cold in his/her room. Resident 3 stated, "My room is always cold sometimes it gets down to 62

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N 502	Continued From page 48 degrees F. Supposedly the facility fixed the boiler, but even with the boiler supposedly fixed it's still cold in my room...My room never gets to 74 degrees F. I have to keep my door open and stay under a ton of blankets to keep warm." On 02/18/2025 at 7:00 AM, Surveyor interviewed Family Member I. Family Member I stated, "I visit [Resident 3] several times a month and [Resident 3's] bedroom temperature has been down to 63 degrees F. [Resident 3] is always cold...I don't think the wall thermostat works in [Resident 3's] room because when you increase the temperature, nothing changes." On 02/18/2025, Surveyor reviewed a WRPD (Wisconsin Rapids Police Report) dated 01/11/2025 which indicated, "[Resident 3] states it's freezing in [her/his] room and won't turn up the heat..." On 02/17/2025 at 11:05 AM, the above findings were discussed with Executive Director A. Executive Director A stated, "[Resident 3's] door has been closed, but we can get it looked at." The provider did not provide tempered air at all times to eliminate cold air drafts. The heating system was not capable of maintaining temperatures of 74 degrees F in Resident 2's and Resident 3's room.	N 502		
N 637	83.59(1)(g) Proper exit locations, sidewalks, driveways. All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2	N 637		

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CRANBERRY COURT ASSISTED LIVING II	2230 JAMES CT WISCONSIN RAPIDS, WI 54494

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N 637	Continued From page 49 habitable floors may have one exit from the second floor. Exits, sidewalks and driveways used for exiting shall be kept free of ice, snow, and obstructions. For facilities serving only ambulatory residents, the CBRF shall maintain a cleared pathway from all exterior doors to be used in an emergency to a public way or safe distance away from the building. For facilities serving semi-ambulatory and non-ambulatory residents, a CBRF shall maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2 primary exits from the building. All other required exits shall have at least a cleared pathway maintained to a public way or safe distance from the building. An exit door or walkway to a cleared driveway leading away from the CBRF also meets this requirement. This Rule is not met as evidenced by: Based on observation and staff interviews the provider did not ensure that 3 of 6 exit pathways lighted with exit signs were clear of ice and snow. This facility is licensed as a Class CNA (non-ambulatory). A class CNA non-ambulatory CBRF (Community Based Residential Facility) serves residents who are ambulatory, semi-ambulatory or non-ambulatory, but one or more of whom are not physically or mentally capable of responding to a fire alarm by exiting the CBRF without help or verbal or physical prompting. This facility serves residents who are advanced aged, terminally ill, developmentally disabled, physically disabled, and who have irreversible dementia or Alzheimer's disease. Findings include:	N 637		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015631	A. BUILDING: _____ B. WING _____	C 03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 637	Continued From page 50 On 02/17/2025 at approximately 10 AM during tour with ED (Executive Director) - A, Surveyor observed 3 exits going out the side doors to be covered in approximately an inch of snow with rabbit tracks in them. These were the exits next to rooms 3, 8, and 13. The last snow in this area was on 02/15/2025. All 3 of these exits had lit exit signs indicating a path to exit. ED - A confirmed these were usable exit passages and that they should have been shoveled on 02/16/2025. ED - A indicated being dissatisfied with their current snow removal company.	N 637		