STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016083	A. BUILDING: _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATHERWOOD (CBRF)	4510 GATEWAY DR EAU CLAIRE, WI 54701

(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 01/17/2024, Surveyor conducted a complaint investigation at Heatherwood CBRF. Data collection continued through 01/25/2024. The complaint was substantiated. Three deficiencies were identified. 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 complete an investigation and document an allegation of caregiver misconduct	N 158		

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

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after it was reported.

Findings include:

This facility is licensed to serve up to 8 residents in the client group irreversible dementia/Alzheimer's, advanced aged, terminally ill, and physically disabled.

On 11/28/2023, the Department received a complaint with an allegation of caregiver misconduct.

On 01/17/2024, Surveyor entered the facility and interviewed Administrator A if there were any investigations conducted related to allegations of caregiver misconduct. Administrator A had a hire date of 11/14/2023 and stated s/he had not completed any investigations since s/he was hired.

Surveyor asked if s/he was aware of any concerns brought to his/her attention related to photos of residents and staff use. Administrator A stated s/he had been notified by Wellness Coordinator (WC) B that Caregiver C reported Caregiver D had taken a photo of Resident 1 and sent it to Caregiver C's phone. Administrator A informed Surveyor s/he was directed by Supervisor E to provide training to staff on not using photos in any capacity.

Surveyor requested to review documentation of the staff training and investigation into the allegations from Administrator A. Administrator A stated s/he did not conduct a formal investigation into the allegations reported by WC B and did not document the staff training. Surveyor asked Administrator A what the training consisted of. Administrator A stated s/he discussed "not using

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N 158	Continued From page 2 photos in any capacity at the morning stand-up meeting." Administrator A stated s/he did not maintain any paperwork for who was present at the meeting, did not complete an investigation into the allegations, and did not interview Caregiver C or Caregiver D about the reported allegation.	N 158		
N 284	83.26(2) Orientation, continuing education documented Employee orientation and hours of continuing education shall be documented in the employee ' s file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure orientation and hours of continuing education were documented in the employee's file for 2023. Findings include: This facility is licensed to serve up to 8 residents in the client groups, irreversible dementia/Alzheimer's, advanced aged, terminally ill, and physically disabled. On 11/28/2023, the Department received a complaint regarding staff training. On 01/17/2024, Surveyor requested a sample of 4 staff records to review for orientation training and continuing education for 2023. RECORD REVIEW CAREGIVER C	N 284		

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N 284	Continued From page 3 Caregiver C had a hire date of 09/23/2022. Caregiver C's record contained a document with the title, "EMPLOYEE ORIENTATION - ALL NEW EMPLOYEES" that contained Caregiver C's initials but did not contain the instructor's initials and was not signed by the instructor. Caregiver C's record did not contain continuing education hours for 2023. CAREGIVER D Caregiver D had a hire date of 09/08/2022. Caregiver D's record contained a document with the title, "EMPLOYEE ORIENTATION - ALL NEW EMPLOYEES" that contained Caregiver D's initials but did not contain the instructor's initials and was not signed by the instructor. Caregiver D's record did not contain continuing education hours for 2023. CAREGIVER E Caregiver E had a hire date of 10/19/2016. Caregiver E's record contained a document with the title, "EMPLOYEE ORIENTATION - ALL NEW EMPLOYEES" that was complete with Caregiver E's initials and instructor initials and was signed by the instructor. Caregiver E's record did not contain continuing education hours for 2023. CAREGIVER F Caregiver F had a hire date of 10/10/17. Caregiver F's record contained a document with the title, "EMPLOYEE ORIENTATION - ALL NEW EMPLOYEES" that did not contain any initials	N 284		

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N 284	Continued From page 4 from Caregiver F or the instructor but did contain the instructor's signature. Caregiver F's record did not contain continuing education hours for 2023. INTERVIEW On 01/18/2024 at 2:40 PM, Surveyor interviewed Administrator A about the incomplete orientation forms for Caregiver C and Caregiver D and the missing continuing education hours for 4 of 4 employees reviewed for 2023. Administrator A informed Surveyor s/he was recently hired in November 2023 and could only locate staff meetings for January through May of 2023.The staff meeting agendas were not tracked for individual employees who were in attendance and did not contain length or duration of the topics discussed to show how many hours were received. Administrator A confirmed there was not sufficient documentation available to show Caregiver C, Caregiver D, Caregiver E and Caregiver F received or met the 15-hour continuing education requirement for 2023. Administrator A stated s/he would work on implementing a system in place for the current year to better track and document continuing education for all employees.	N 284		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented.	N 385		

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N 385	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the provider did not prepare and implement a written temporary service plan (TSP) to meet the immediate needs of the resident. Findings include: This facility is licensed to serve up to 8 residents in the client groups irreversible dementia/Alzheimer's, advanced aged, terminally ill, and physically disabled. On 11/28/2023, the Department received a complaint regarding resident care plans. RECORD REVIEW Resident 1 had an admission date of 10/31/2023 and was discharged on 11/29/2023. Resident 1 was admitted to the community based residential facility (CBRF) from the Residential Care Apartment Complex (RCAC); attached and located under the same roof. On 01/17/2024, Surveyor requested to review Resident 1's record, including the pre-admission assessment, individual service plan (ISP), TSP and staff charting notes. The following documents were provided by Administrator A: STAFF CHARTING OBSERVATION NOTES (read in part): -10/31/23: Moved to Memory Care Community. -10/31/23 at 8:45 AM: "Write [sic] went to [his/her] room to administer [his/her] morning medications and [s/he] began screaming at staff. [S/he] was	N 385		

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looking for [spouse]. Writer told [him/her] that [s/he]s [sic] in other facility and that [s/he] needs more cares. [S/he] responded with yelling tone [sic] stated [sic] 'So I'm just gonna [sic] die here alone? [Expletive] this! [Expletive] you!' Writer told [him/her] that wasn't nice and [s/he] should calm down. [S/he] did [sic] took [his/her] meds and had writer dial number for [him/her] and apologised [sic] for what [s/he] said. [S/he] also refused, [sic] cares, breakfast, vitals."

-10/31/23 at 9:45 AM: "resdident [sic] was repeating [him/herself] and questioning where is [sic] [spouse] was, we tryed [sic] multiple times to distract [him/her] and change topic, resd [sic] got frustrated with staff and slmammed [sic] [his/her] font [sic] door when offered breakfast [s/he] refused all food and drink and i [sic] myself didnt [sic] feel comfortable in [his/her] room alone with [him/her] [sic] [s/he] got in my face a few times and was yelling . [sic]"

-10/31/23 at 11:00 AM: "To all employees regarding [room #] [Resident 1] we need to be honest with [him/her] when [s/he] asks where is [sic] [spouse] is at tell [him/her] [his/her] [spouse] is at another location and lives elsewhere so [s/he] can get the best care [s/he] can get and that there [sic] still married and that there [sic] living in separte [sic] places now. Please do not tell [him/her] [s/he] is next door that has and will make [him/her] worse regarding that [s/he] has gotten frustrated about where [his/her] whereabouts have been and will raise [his/her] voice towards you and make [him/her] more upset. thanks [sic] so much everyone for working together on trying to make this easier transition for [him/her] and us."

- 11/01/23 at 12:45 PM: "resdient [sic] came out

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of [his/her] room at 1245 pm today and strated [sic] yelling at other resdients [sic] asking them about where [his/her] [spouse] was [sic] [s/he] upset one resdient [sic] to the point of crying . [sic] [s/he] [sic] then repeated asking where [s/he] was and we redirected [him/her] on a differnt [sic] topic. [S/he] then went back to [his/her] room."

-11/02/23 at 8:45 AM: "Resident is very distraut [sic] and is weeping very loudly and has been asking about [his/her] [spouse]."

-11/06/23 at 8:45 AM: "Per [child]s request, [his/her] phone number has been removed from residents [sic] room [s/he] would not like [him/her] to call [him/her]."

-11/06/23 at 1:45 PM: "Resident came out of [his/her] room yelling... Resident 1 started screaming at staff and said, 'I am going to call cops, just watch' [sic] then slammed the door hard that scared two of the residents in the hallway."

-11/06/23 at 4:25 PM: "Resident very upset punching the wall yelling obscenities at writer and threw [his/her] med cup stated [sic] [s/he] is going to call the police."

-11/07/23 at 10:30 PM: Resident was sent to hospital.

-11/07/23 at 11:15 PM: "Got a call around 1120pm from [hospital] saying they are having [Resident 1] come back home. No changes to anything. [S/he] was a little dehydrated. GIving [sic] fluids there then will be back within an hour or so."

-11/14/23 at 11:30 AM: "we [sic] are now suppose [sic] to tell [Resident 1] [s/he] is seperated [sic]

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from [his/her] wife because [s/he] is getting help for [his/her] memory [s/he] [sic] was not recognizing [him/her] or [his/her] family so they had to be seperated [sic]. Per APOA (activated power of attorney) from [Hospice RN] (registered nurse)."

-11/18/23 at 2:00 PM: "Resident stated [s/he] wanted to kill [him/herself] today. [S/he] stated this after talking with [his/her] [sibling]. [S/he] has been asking about [his/her] wife alot [sic] and also asking why is [s/he] at [provider name]."

-11/19/23 at 1:30 PM: "...Resident came out of [his/her] room multiples times asking for [spouse]. Staff was able to redirect [him/her] back to [his/her] room. [S/he] also ate most of [his/her] lunch today. [S/he] did tell staff multiple times that [s/he] wanted to just die and had some sucidal [sic] ideation. [S/he] took [his/her] scheduled meds today with some encouragment [sic]. Writer was also able to give [him/her] [his/her] PRN (as needed) haldol [sic] to help with [his/her] sleeping and agitation. Staff helped [him/her] get into pjs (pajamas) so [s/he] was ready for the night."

-11/21/23 at 11:45 AM: "[Resident 1] Redirection [sic] per family request: If resident request information or questions where [his/her] [spouse] is at, please redirect [him/her] by stating that [s/he] has been confused and is having a difficult time remembering who [his/her] family is. Due to this, [s/he] has been scared and requires more care and is unable to be with [him/her] to help [him/her] with [his/her] [condition]. If anyone tries to tell you to redirect [him/her] any differently (hospice, care companions, etc.), please send them to the Administrator for clarification. You may give them [his/her] cell phone number if need be."

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N 385	Continued From page 9 -11/21/23 at 9:45 PM: "Resident commited [sic] about having staff bring a knife to [him/her] so [s/he] could cut something, staff 'asked about cutting what' , [sic] Resident replied [sic] "something", staff asked again. [sic] 'cut what?' Resident said nevermind. [sic] Resident again later replied [sic] 'I'm going to kill myself,' then everything would be better. Again [sic] later resident said [sic] 'I'm going to pray to God that [s/he] takes me'. [sic] -11/26/23 at 8:45 AM: "Resident threw [him/herself] on floor yelling for [spouse] [sic] took two staff to help [him/her] up and into [his/her] room." -11/27/23 at 11:45 AM: "Resident will be moving out of [facility name] on Wednesday, 11/29/2023. Time has not been determined. When family arrives, please notify Administrator. GROWTH & WELLNESS PLAN 90 DAY ASSESSMENT: ROUTINE ASSESSMENT This document was dated 08/26/2023 and was completed for Resident 1 when s/he resided in the RCAC. The assessment showed the following information: -Responsible party: "Self" was checked -Advanced Directive: "Yes" was checked with Health Care Power of Attorney listed -Is Healthcare POA Activated: "Yes" was checked -Health information evaluation: "I need some assistance with the call system." -Evaluation (read, in part): "05/25/23 - Resident is adjusting fairly to placement at [facility name] ... [S/he] relies heavily on [his/her] [spouse] as a caregiver at this time. [His/her] dementia does	N 385		

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seem to be getting worse per [his/her] [spouse]. [Resident 1] is moving in with [his/her] [spouse]. [S/he] does not know where [s/he] is sometimes and is not happy about leaving their home, [sic] but is willing to do what [spouse] thinks is [sic] right as [s/he] hasn't lead [sic] [him/her] wrong yet. Staff will provide reminders and redirection for [him/her]."
-Cognition: Tenant has dementia where [his/her] short term memory has been affected. [S/he] doesn't remember where [s/he] is sometimes and looks for reminders. [S/he] depends on [his/her] [spouse] to guide [him/her] in [his/her] daily living.
-Fall Risk: "High."
-Continence Care: Incontinent of urine occasionally or rarely.
-Toileting Bowel: "Independent"
-Psychosocial: the following items were checked regarding behavioral issues present- forgetful, adjustment difficulty, withdrawn or lethargic.

The assessment on file used for pre-admission to the CBRF was completed approximately 2 months prior to the transfer and did not identify or accurately assess Resident 1's behavior for "adjustment difficulty" when Resident 1 would be separated from his/her spouse.

TEMPORARY ISP

On 01/18/2024, Surveyor reviewed the TSP provided by Administrator A. Administrator A stated they did not have a 30-day comprehensive plan available as Resident 1 discharged on day 30.

The TSP had several areas that were left blank and identified the following areas related to behaviors:

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-"Hourly safety check: Staff will note resident's whereabouts every hour while awake due to wandering behavior.
-Cognitive function--Moderately Challenged: Some memory loss which can lead to anxiousness or agitation. May be confused, depressed, isolated. Judgement and memory are frequently poor. Requires frequent cueing, support, and validation. Daily @ As Needed."

The TSP available to staff did not identify interventions for staff or Resident 1's current behaviors upon admission to the CBRF related to yelling, suicidal ideation or verbal threats documented in staff charting.

INTERVIEW

On 01/17/2024 at 12:55 PM, Surveyor interviewed Caregiver F about Resident 1's care needs. Caregiver F stated Resident 1 was not there long and was very challenging to care for. Caregiver F further stated Resident 1 was verbally abusive and screamed, would throw him/herself down on the floor, would scare other residents, and called for spouse constantly. Caregiver F stated s/he assumed the family made the decision to move Resident 1. Caregiver F stated s/he did not recall seeing an individual service plan for Resident 1 but had dealt with residents like Resident 1 in the past since s/he had "several years of experience working with dementia residents."

On 01/17/2024 at approximately 4:00 PM, Surveyor interviewed Life Enrichment Coordinator (LEC) G about Resident 1's care needs. LEC G stated that Resident 1 was one of the most challenging residents behaviorally that they have admitted to the CBRF. LEC G informed Surveyor

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that the facility did help facilitate getting hospice services on board to assist with Resident 1's care but ultimately the family decided to move Resident 1.

On 01/18/2024 at 3:30 PM, Surveyor interviewed Caregiver C about Resident 1's care needs. Caregiver C stated Resident 1 had several behaviors and aggression. Caregiver C further stated that Resident 1 was very combative with cares and was incontinent of urine and bowel movements and would smear feces all over his/her bathroom. Caregiver C stated staff did not know or have direction on a care plan, was not prepared to manage Resident 1's behaviors and were not directed on what to say to Resident 1 when s/he was looking for his/her spouse.

SUMMARY

Staff charting documentation showed Resident 1 exhibited behaviors moving away from his/her spouse upon admission. The pre-admission assessment on file identified Resident 1 relied heavily on spouse for support and assistance. The TSP available to staff did not address Resident 1's behaviors or suicidal ideations and did not identify interventions for staff to meet the immediate needs of the resident, until the ISP was developed and implemented.