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N 000	Initial Comments On 08/05/2024, Surveyor conducted an onsite visit at Apple Avenue Group Home to investigate two (2) complaints. Additional information was gathered through 08/15/2024. Both complaints were substantiated, and 6 new deficiencies were identified. Census: 5	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 interviews and record review, the provider did not investigate and document allegations of verbal abuse by Caregiver A.	N 158		

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

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N 158	Continued From page 1 Finding include: The provider is licensed to care for up to 6 residents who may have irreversible Dementia/Alzheimer's, traumatic brain injury, developmentally disabled, emotionally disturbed/mental illness, and/or physically disabled. On 07/29/2024 and 07/31/2024, the Department received complaints alleging verbal abuse to residents. On 08/05/2024 at 11:40 AM, Surveyor interviewed Resident 1 and asked whether staff treats him/her with dignity and respect. Resident 1 recalled an incident where Caregiver A called him/her a "dumb [explicit]." Surveyor asked Resident 1 how that made him/her feel. S/he pinched his/her thumb and middle finger together and stated, "This short," and that Caregiver A "wasn't just picking on me that day." On 08/05/2024 at 2:00 PM, Surveyor interviewed Resident 2 and asked whether staff treat him/her with dignity and respect. Resident 2 recalled an incident on 07/14/2024, where Caregiver A "made fun" of him/her for being "blind," "disabled" and living in a "group home." Resident 2 stated s/he also witnessed Caregiver A calling Resident 1 a "dumb [explicit]." Resident 2 described staying in his/her room and tries to "hold off smoking" while Caregiver A is working in order to avoid Caregiver A. Resident 2 said s/he does not feel safe when [Caregiver A] is working. On 08/05/2024 at 4:30 PM, Surveyor interviewed Caregiver H. S/he recalled a time when s/he observed Caregiver A calling Resident 1 a "dumb [explicit]." Caregiver H said s/he sent a statement	N 158		

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N 158	Continued From page 2 to Division Administrator B following the incident. S/he also recalled a time when Caregiver A told Resident 3, "I am not playing your [explicit] games anymore," following a coughing episode. On 08/08/2024, Surveyor sent an email to Division Administrator B requesting all documentation of internal investigations completed during 2024 regarding abuse, neglect, and/or misappropriation. On 08/09/2024, Division Administrator B replied to the e-mail which read in part, "I received Nothing for this from HR [sic-all]." Following Surveyor's request on 08/09/2024, Division Administrator B emailed a document titled, "Caregiver Investigation Procedure," which read in part: " ...This protocol must be implemented immediately when any of the following occurs: Receiving a verbal or written statement of a resident, caregiver or anyone with knowledge of an incident ... IMMEDIATELY FOLLOWING INCIDENT ... Step One: Protect The Resident ... Supervisor immediately removes the accused caregiver from the immediate consumer care area ... WITHIN 24 HOURS OF INCIDENT DISCOVERY ... Assigned Investigators [sic] will conduct interviews and obtain written, signed statements from all witnesses or persons with information ...	N 158		

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N 158	Continued From page 3 Investigators will obtain a detailed account of the incident from the resident including feelings, pain or discomfort ... Abuse is any of the following acts committed by a caregiver: ... Causes or could reasonably be expected to cause mental or emotional damage to a resident, including harm to the resident's psychological or intellectual functioning that is exhibited by anxiety, depression, withdrawal, regression, outward aggressive behavior, agitation, or a fear of harm or death, or a combination of these behaviors ..." On 08/07/2024, Adult Protective Services (APS) I provided Surveyor a document s/he received from the provider titled "Employee Warning Notice" for a violation of "unacceptable conduct." The document contained details of an incident that occurred on 07/14/2024, where Caregiver A stated "dumb [explicit] like you" to a resident. The document read in part, "Consumer took this statement personally and found it offensive." The document contained a written warning for Caregiver 1 to "keep conversation clean when speaking to consumer." The document was dated 07/24/2024 and prompted for signatures from the employee, supervisor, and HR; all signature lines were` blank. The document prompted for "supporting documentation" to be attached to the document. The document did not include attached documentation of interviews or written statements of caregivers or residents who may have been involved in or witnessed the conduct. On 08/08/2024, Surveyor asked Division Administrator B to provide all documentation of an investigation or staff disciplinary action surrounding the incident that occurred on	N 158		

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N 158	Continued From page 4 07/14/2024. Ultimately, Division Administrator B was unable to provide the requested documentation. On 08/07/2024, Power of Attorney (POA- legal decision maker for health care) F e-mailed Surveyor regarding a conversation Resident 1 had with his/her physician that day. POA F expressed concern because during the appointment Resident 1 told the physician s/he does not feel safe at home and when asked to explain more s/he said s/he feels unsafe "when [Caregiver A] is around." On 08/15/2024 at 2:00 PM, Surveyor interviewed Chief Executive Officer D, Case Management Director C, and Division Administrator B. Division Administrator B said s/he notified human resources regarding Caregiver A stating, "[explicit] like you," to Resident 1 and the recommendation was to "do a disciplinary" on Caregiver A. Division Administrator B confirmed that Caregiver A was hired in January 2024 and had been working as a caregiver for the past 6 months. Chief Executive Officer D, Case Management Director C, and Division Administrator B did not provide additional steps that were taken in response to the 07/14/2024 incident and acknowledged that an investigation had not been completed. On 07/14/2024, Caregiver A belittled Resident 1 when s/he called him/her a dumb [expletive]. The incident was witnessed by Resident 2 and Caregiver H and was reported to management. The provider did not take immediate steps to ensure the safety of residents or conduct an investigation into the incident. The provider did not take action to determine the scope of Caregiver A's behavior towards Resident 1 or to determine if s/he was engaging in similar	N 158		

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N 158	Continued From page 5 behavior towards other residents. Three weeks after the incident Caregiver A continued to provide direct care to Residents 1 and 2. During Surveyor's investigation, Resident 2 reported additional incidents of verbal/emotional abuse by Caregiver A and both Resident 1 and Resident 2 reported they do not feel safe in the home when Caregiver A is working. Cross Reference: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0362 DHS 83.33(1)(d) Grievance Procedure: Written Summary Z0023 DHS 50.065(4m)(b) Caregiver Hiring and Contracting Process	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 interview and record review the facility did not ensure Resident 2 received the correct insulin injection. Findings include: The provider is licensed to serve up to 6 residents who may have irreversible Dementia/Alzheimer's, traumatic brain injury, developmentally disabled, emotionally disturbed/mental illness, and/or	N 352		

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physically disabled.

On 07/31/2024, the Department received a complaint which included medication administration concerns.

On 08/05/2024 at 9:10 AM, Surveyor interviewed Caregiver E regarding resident needs. Caregiver E described Resident 2 as "self-sufficient," "blind," and "diabetic" requiring insulin and assistance administering his/her medications.

On 08/05/2024 at 9:30 AM, Surveyor reviewed "Incident Report" dated 07/05/2024 at 06:30 AM regarding "Medication - Error" where "...noc shift gave [Resident 2] the wrong insulin before breakfast ..." S/he received his/her " ...long acting one in am ..." and " ...not [his/her] short acting one ..." "Resident statement" included "I can tell it's the wrong one because of the shape and the clicks."

On 08/05/2024, following Surveyor request, Caregiver E provided Resident 2's MARs (medication administration records) for May, June, July, and August. Surveyor noted the following on Resident 2's July 2024 MAR:

-- " ...BASAGLAR KWIKPEN 100UNIT/ML ...Start Date ...04/10/24 ...INJECT 14 UNITS SUB-Q AT BEDTIME ..."
-- " ...ADMELOG SOLOSTAR 100UNIT/ML ...Start Date ...04/09/24 ...INJECT SUB-Q 3 TIMES DAILY BEFORE MEALS ..."

On 08/08/2024 at 4:20 PM, Surveyor interviewed Caregiver A. S/he acknowledged an incident where s/he accidently administered Resident 2 his/her "long acting (insulin)" instead of his/her "short acting (insulin)" which led to Resident 2

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N 352	Continued From page 7 injecting him/herself with the incorrect insulin. On 08/05/2024 at 2:00 PM, Surveyor interviewed Resident 2 and asked a general question about his/her needs regarding medications. S/he explained that staff "dial up" the insulin dose and hand it to him/her to inject. S/he recalled an incident in July where Caregiver A provided him/her with the incorrect insulin which s/he injected him/herself with. Resident 2 stated the "short acting (insulin) clicks for every unit" and the "long acting (insulin) is fatter" which is how s/he knew it was the incorrect insulin. Resident 2 stated s/he felt "aggravated and kind-of worried" with the staff and him/herself following the incident. Cross Reference: N0389 DHS 83.35(3)(d) Service Plans Updates Annually Or On Change of Conditions Z0023 DHS 50.065(4m)(b) Caregiver Hiring and Contracting Process	N 352		
N 362	83.33(1)(d) Grievance procedure: written summary The CBRF shall provide a written summary of the grievance, the findings and the conclusions and any action taken to the resident or the resident ' s legal representative and the resident ' s case manager. The CBRF shall maintain a copy of the investigation. This Rule is not met as evidenced by: Based on interviews, observation and record review, the CBRF did not provide a written summary of all grievances with the findings,	N 362		

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conclusions, and any action taken to residents in response to grievances regarding Resident 1 and Resident 2.

Findings Include:

The provider is licensed to care for up to 6 residents who may have irreversible Dementia/Alzheimer's, traumatic brain injury, developmentally disabled, emotionally disturbed/mental illness, and/or physically disabled.
Findings include:

On 07/29/2024 and 07/31/2024, the Department received complaints alleging verbal abuse to residents.

Example 1: Resident 1

On 08/05/2024 at 11:40 AM, Surveyor interviewed Resident 1. S/he described an incident where Caregiver A called him/her a "dumb [explicit]" which occurred in July 2024. Resident 1 notified his/her Power of Attorney (POA - legal decision maker for health care) F regarding the incident immediately after Caregiver A left the facility. Since the incident, Resident 1 said staff had not spoken with him/her regarding the outcome or follow-up.

On 08/08/2024 at 8:41 AM, Surveyor interviewed Division Administrator B. S/he acknowledged a recent disciplinary action involving an incident where Caregiver A called Resident 1 a "dumb [explicit]."

On 08/05/2024 at 12:05 PM and 08/07/2024 at 2:11 PM, Surveyor interviewed POA F. S/he recalled speaking with Caregiver H, Caregiver L,

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and Division Administrator A "on Friday" regarding concerns related to Caregiver A. S/he said an individual from Clarity Care had informed him/her that issues are being investigated but had not received any follow-up as of Surveyor's last interview on 08/07/2024.

Following Surveyor's request, on 08/07/2024 POA F provided an email correspondence sent to Division Administrator B, Public Funding Source J and Public Funding Source K on 07/20/2024. The email read in part, "I need to make you aware of a verbal abusive action taken towards [Resident 1] by [Caregiver A] ...[Caregiver A] asked [Resident 1], 'Do you know what DA stands for?...It stands for a DUMB [explicit] like you.' [Resident 1] was affected by what [s/he] said. [S/he] was nervous to get out of bed ...[Caregiver A] ...applied the dressing too tight on [his/her] toe ...[Caregiver H] asked another resident if [s/he] had heard the comment and [s/he] had. [S/he] then made out two reports. I have contacted [Division Administrator B] and another staff member ... [sic-all]"

On 07/22/2024, Division Administrator B sent an email response to POA F which read, "Taking care of, thank you for your concerns [sic-all]."

On 07/22/2024, POA F sent an email response to Division Administrator B which read in part, "Was that taken care of, by putting peroxide on [his/her] toe this morning? It is stated clearly in the doctor's notes, that the bandage is to be changed daily. Nothing less, nothing more. The doctor didn't even use anything more than sterile water to irrigate the toe ...I understand that it's gross to look at, but just dress it. If staff thinks it's getting worse, than I need a phone call ...[sic-all]" The email did not contain a response from Division

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Administrator B following POA F's most recent concerns.

On 08/07/2024 at 2:11 PM, Surveyor interviewed POA F and s/he stated, "Right now [Resident 1] does not feel safe."

Example 2: Resident 2

On 08/05/2024 at 2:00 PM, Surveyor interviewed Resident 2 (own decision maker). S/he recalled witnessing an incident where Caregiver A called Resident 1 a "dumb [explicit]" on 07/14/2024. Resident 2 said s/he spoke with Division Administrator B the following day as s/he "usually does not answer on the weekends" regarding his/her concerns related to Caregiver A. Resident 1 said s/he notified both Family M and Case Manager N regarding the concerns about Caregiver A. Resident 2 stated s/he also had brought up concerns in the past regarding Caregiver A but "nothing was done" and felt disregarded. Resident 2 equated it to "being given the middle finger" and said "enough is enough."

Following Surveyor request, on 08/08/2024 Division Administrator B provided document titled "Grievance Resolution Process." The document read in part, "A written summary of the grievance, the findings and the conclusions and any action taken shall be provided to the resident or the resident's guardian, agent or designated representative and the resident's case manager, if any, and shall be inserted in the residents record."

On 08/08/2024 at 3:00 PM, Surveyor interviewed Family M. S/he said Resident 2 was upset after Caregiver A belittled him/her and making fun of

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him/her for being blind. S/he said s/he emailed Division Administrator B regarding concerns of verbal abuse and received minimal feedback since.

Following Surveyor request, on 08/08/2024 Family M provided an email correspondence sent to Division Administrator B on 07/21/2024 which read in part, "...[Resident 2] ...was pretty upset about a few things ...[s/he] was most upset about ...[Caregiver A] verbally abusing residents. [S/he] told me [s/he] was making fun of [him/her] because [s/he] was blind and in an assisted living facility ...[Resident 2] also told me [s/he] was given the wrong insulin last week, [s/he] caught [him/her] sleeping several times and [s/he] smells like Marijuana ...Will you please ask [Resident 2] about this and look into what is going on ... [sic-all]"

On 07/22/2024, Division Administrator B sent an email response to Family M which read, "We are already looking into this matter, thank you for your concerns [sic-all]."

On 08/14/2024 at 12:00 PM, Surveyor interviewed Case Manager N. S/he said s/he was notified of concerns regarding Caregiver A and was forwarded the aforementioned email correspondence from Family M to Division Administrator B on 07/24/2024 regarding Resident 2's verbal abuse concerns with Caregiver A. S/he said s/he had not been previously informed by Clarity Care of verbal abuse concerns regarding Caregiver A prior to Family M's email. In addition, s/he had not received incident reports following two separate medication errors involving Resident 2.

Following Surveyors request, on 08/14/2024

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Case Manager N provided an email correspondence sent to Director of Organizational Development O on 07/24/2024 which read in part, "I haven't received any updates regarding the investigation for [Resident 2] ...[s/he] has ...reached out to [his/her] [parent] with ...concerns ...[s/he] reached out to [Division Administrator B] ...all she received back was a short response. Some follow-up on this will be much appreciated. In addition, there was a medication error with [his/her] insulin ...however, an incident report was not provided to us as is the protocol ...If you have any updates regarding the investigation that would be appreciated ...[sic-all]."

On 07/25/2024, Director of Organizational Development O sent an email response to Case Manager N which read in part, " ...The situation if question was reported to us on Monday, the staff in question has been disciplined and pop in visits are being completed ...I am following up on the possible med error ...[sic-all]."

As of 08/14/2024, Case Manager N had not received further follow-up regarding concerns of verbal abuse involving Caregiver A.

On 08/08/2024 at 8:41 AM, Surveyor interviewed Division Administrator B. Surveyor asked about grievances involving Resident 2. Division Administrator B stated, "[Resident 2] likes to complain about everyone" and s/he complained about Caregiver A "sleeping on the job." Division Administrator said Caregiver A was disciplined and received a "job in jeopardy" in regards to sleeping on the job.

On 08/15/2024 at 2:00 PM, Surveyor interviewed Chief Executive Officer D, Case Management C, and Division Administrator B in regards to

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N 362	Continued From page 13 grievances involving verbal abuse by Caregiver A. Division Administrator B acknowledged the aforementioned emails and that Human Resources recommendation was to do a "disciplinary." Chief Executive Officer D, Case Management C, and Division Administrator B acknowledged that ultimately Resident 2, POA F, and Case Manager N were not provided with a written summary of the grievance, the findings, and the conclusions. Cross Reference: N0158 DHS 83.12(2)(a)2 Caregiver: Investigating Abuse and Neglect N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication Z0023 DHS 50.065(4m)(b) Caregiver Hiring and Contracting Process	N 362		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by:	N 389		

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N 389	Continued From page 14 Based on interview and record review, the provider did not ensure Resident 1's and Resident 2's individual service plan (ISP) was updated with a description of services the provider would offer to meet Resident 1's needs related to his/her pressure injury and prevention and Resident 3's diagnosis of type 1 diabetes and medication management. Findings include: The provider is licensed to care for up to 6 residents who may have irreversible Dementia/Alzheimer's, traumatic brain injury, developmentally disabled, emotionally disturbed/mental illness, and/or physically disabled. On 07/29/2024 and 07/31/2024 the Department received complaints alleging concerns about services provided to residents. Example 1 - Pressure Injury Interviews: On 08/05/2024 at 9:10 AM, Surveyor interviewed Caregiver E regarding Resident 1's needs. S/he stated Resident 1 had "something wrong with [his/her] big toe" and that it "does not look very good." S/he explained night shift staff typically provide cares for the injury and stated, "They just have to re-wrap it every other day or something," and was unsure what his/her "doctor is doing for it." Caregiver E was unaware of the need for daily documentation regarding the injury and said s/he had not completed any. On 08/05/2024 at 11:40 AM, Surveyor interviewed Resident 1 and inquired about his/her sore on the	N 389		

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toe. Resident 1 said s/he has had the injury for three weeks and that the toenail was removed "probably ...two weeks ago." Resident 1 described the toe as looking "terrible" and that staff are "changing (the) bandaging every other day." Resident 1 stated "[Caregiver A] thought it was a good idea to put peroxide on the foot" which was not ordered by a physician.

On 08/05/2024 at 12:04 PM and 08/07/2024 at 2:11 PM, Surveyor interviewed Power of Attorney (POA - legal decision maker for health care) F regarding Resident 1's toe. S/he stated, "[Caregiver A] once again ...put peroxide on it (toe)." Caregiver A also "taught [Caregiver E]" to apply peroxide to the toe. POA F said Caregiver A applied his/her "dressing too tight" and the "pressure ulcer" was caused by Resident 1's shoe "rubbing" on the toe. S/he said the area on Resident 1's toe is "black ...(with) dead skin" due to the area not having "any blood flow."

On 08/05/2024 at 3:56 PM, while requesting access to Resident 1's records, Surveyor observed the following on Resident 1's ECP (electronic charting system):

"SKIN CHECK ...Start Date: 08/05/2024 ...Left Toe needs to be check daily, every shift [sic-all]."

On 08/07/2024 at 1:15 PM, Surveyor interviewed Caregiver G and asked about the injury on Resident 1's toe. Caregiver G said Resident 1 injured his toe "in the shower" approximately 3 weeks ago. s/he described the injury as getting "worse over time. Caregiver G said staff was to "keep an eye on it" and to contact the doctor if it "got worse" and that staff was "not supposed to use peroxide." S/he said "skin checks" are to be completed "3 times a day" which was new as of

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N 389	Continued From page 16	N 389		

"a few days ago." Caregiver G was unaware of any expectation prior to that for daily monitoring, charting or bandage changes.

On 08/08/2024 at 8:41 AM, Surveyor interviewed Division Administrator B regarding Resident 1's toe. S/he described skin checks per protocol are completed regularly and when there is a change. S/he acknowledged that skin checks were first initiated on 08/05/2024 and s/he had requested staff to complete an incident report regarding the toe, but s/he had not seen the report yet.

Record Review:

Following Surveyor s request, On 08/08/2024 Division Administrator B emailed surveyor the ISP, TAR and physician order's regarding Resident 1's toe. Surveyor reviewed the records on 08/08/2024, and noted the following:

Resident 1 was admitted to the facility on 12/11/2023 with diagnoses which include type 1 diabetes, chronic kidney disease, hypertension, and mild intellectual disabilities. Resident 1's Health Care POA was activated.

The physician orders read in part:

-- "07/18/2024 ...change dressing on toe daily dry gauze/telfa with paper tape and co band ...do not get [his/her] Left foot wet ...No closed toe shoes, patient to walk in socks or open toed postop shoe ...patient to take clindamycin antibiotic as prescribed ..." [sic-all]
-- "07/25/2024 ...please change dressing every other day. use gauze and paper tape. Does not need to put anything on the gauze ..." [sic - all]
-- "07/31/2024 ...Plan for procedure on 8/6/24 ..." [sic - all]

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N 389	Continued From page 17 The ISP identified the need for partial assistance with bathing and toileting, full assistance with dressing, partial assistance from staff while ambulating and the use of a walker or wheelchair for mobility. The ISP also identified Resident 1 as a fall risk and included goal to be "pain free" and "free of pressure ulcers." The ISP: -- Did not identify Resident 1's risk for pressure injuries due to diagnoses or immobility. -- Did not identify strategies to prevent skin break down. -- Did not identify the presence of a pressure injury or strategies to manage it. -- Did not contain a signature and date from POA F. According to Cleveland Clinic, "Bedsores are wounds the occur from prolonged pressure on your skin ...These painful wounds ...can grow large and lead to infections ...in some instances ...can be life threatening ... What are other names for bedsores?... -- Pressure injuries. -- Pressure sores. -- Pressure ulcers. -- Pressure wounds ... Bedsores can begin anywhere ... Bedsores occur when pressure reduces or cuts off blood flow to your skin. This lack of blood flow can cause a pressure injury to develop in as little as two hours ...	N 389		

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N 389	Continued From page 18 Who is at risk for bedsores? People who have thinner skin and people who have limited (or no) ability to move are more likely to develop bedsores. These include people who: ... -- Use wheelchairs ... Adults with certain health conditions are more likely to develop bedsores. These conditions include: ... -- Diabetes -- Kidney failure ... What are the stages of bedsores?... -- Stage 1: Your skin looks red or pink, but there isn't an open wound ... -- Stage 2: A shallow wound with a pink or red base develops ... -- Stage 3: A noticeable wound may go into your skin's fatty layer ... -- Stage 4: The wound penetrates all three layers of skin, exposing muscles, tendons and bones in your musculoskeletal system ... What are the complications of bedsores?... You may develop sepsis or require an amputation ... What are the signs of an infected bedsore?... -- Extremely painful. -- Foul smelling. -- Red and very warm to the touch. -- Swollen. -- Oozing pus."	N 389		

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N 389	Continued From page 19 Source: Bedsores (Pressure Ulcers): Symptoms, Staging & Treatment (clevelandclinic.org); retrieval date 08/30/2024. Example 2 - Diabetes and Medication Management On 08/15/2023 at 2:30 PM, Surveyor interviewed Division Administrator B regarding Resident 2's needs. S/he stated Resident 2 is "independent" but needs assistance with blood sugar checks and medication management. On 08/08/2024, Surveyor reviewed resident records including medication administration records (MARs), facesheet, and observation notes. Resident 2 was admitted to the facility on 12/13/2021 with diagnoses which include diabetes, vision impairment, complete amputation at knee level, and major depressive disorder. Upon Surveyors request, on 08/08/2024, Division Administrator B e-mailed Resident 2's most current ISP dated 05/09/2024. The ISP: -- Identified Resident 2 as independent with bathing, dressing, grooming, and toileting. -- Identified needs regarding "Eye Sight" and read in part, "[Resident 2] requires staff assistance to manage vision needs. [Resident 2] vision requires staff for most needs. Staff picks clothes, cuts food and prepares all meals and medication." -- [Resident 2] is a diabetic and requires snacks at designated times. [Resident 2] see a endocrinolists for [his/her] diabetes. [S/he] is doing pretty good with [his/her] numbers [sic-all]." -- Included a section titled "Diabetes	N 389		

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Management" which read, "[Resident 2] requires staff to manage diabetes per physician orders. Are they insulin dependent-diet controlled - med assisted etc, do they do own blood sugars, do they administer their own insulin, how often are blood sugars checked, are they sliding scale insulin, what are the physician orders regarding high/low blood sugars."

The ISP:

-- Did not provide answers to the questions under the "Diabetes Management" section or include information about physician orders or parameters to identify Resident 2's individualized needs, preferences and interventions in this area.
-- Did not identify Resident 2's preferences regarding administration of insulin injections.
-- Contained conflicting information regarding Resident 2's restrictions due to vision impairment and dressing needs.

On 08/15/2024 at 2:00 PM, Surveyor interviewed Chief Executive Officer D, Case Management Director C, and Division Administrator B. Division Administrator B confirmed that the ISP s/he provided to surveyor for both Resident 1 and Resident 2 were current and up-to-date. Following Surveyors review of the documents Chief Executive Officer D, Case Management Director C, and Division Administrator B acknowledged the ISPs for Resident 1 and Resident 2 did not include the aforementioned items.

Cross Reference:
N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication

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N 427	Continued From page 21	N 427		
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 interview and record review, the provider did not provide daily activity programming to meet the needs, interests, and capabilities of the residents. Findings include: The provider is licensed to serve up to 6 residents who may have irreversible Dementia/Alzheimer's, traumatic brain injury, developmentally disabled, emotionally disturbed/mental illness, and/or physically disabled. Division Administrator B provided activity calendars for the months of May, June, July and August 2024 upon Surveyor's request on 08/13/2024. Activities were written on each day, but did not include a time that the activity was offered. Surveyor noted the following activities and occurrences:	N 427		

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N 427	Continued From page 22 -- 19 entries for "outside" -- 16 combined entries for "Movies," "Movie Day," "Movie Night," Popcorn and Movies," Pizza and Movies," and "TV Shows" -- 9 entries for "News" and 1 entry for "News line 9" -- 6 entries for "Bingo" The calendars listed additional activities including "baking day," "music/church," "group chat," "group activity," and "music." Interviews On 08/05/2024 at 11:20 AM, Surveyor approached Resident 1 in the common space and asked a general question about how they were doing. Resident 1 responded, "Bored," and described watching television and playing games on his/her phone. On 08/05/2024 at 11:40 AM, Surveyor interviewed Resident 1 in his/her room and asked about activities offered at the facility. S/he stated since s/he was admitted in January, there have been "no group activities." S/he described his/her previous home that offered "bingo and all sorts of activities" which s/he participated in. Resident 1 stated they "think" the facility has "a calendar" but "they do not manage to do them (activities)." On 08/05/2024 at 2:00 PM, Surveyor interviewed Resident 2 and asked about daily activities. Resident 2 stated staff and him/her "walk around" with Resident 1, but that has "diminished" recently. On 08/08/2024 at 4:20 PM, Surveyor interviewed Caregiver A and asked about the daily activities.	N 427		

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S/he stated they do "movie nights," "smoothie nights," and "popcorn night" and said while they offer things, the residents "don't really do much." Surveyor asked about activities that Resident 1 is interested in and capable of participating in. S/he said "napping activities" and that staff "have tried" to "get [him/her] outside to move around as much as possible." Surveyor asked if residents are offered to participate in Bingo. S/he said it is "on calendar" but residents do not engage in the activity.

Record Review

Upon Surveyors request, on 08/08/2024, Division Administrator B provided Resident 1's most up-to-date ISP (Individualized Service Plan) dated 06/10/2024. The document contained, "Leisure Time Activities" and information that Resident 1 "likes to complete crafts, play bingo, watch TV, listen to classic rock music, and likes to be outside when it's nice out." The ISP identified the resident's desired outcomes as, "Find enjoyment/fulfillment in activities of choice."

Upon Surveyor's request, on 08/08/2024 and 08/09/2024 Division Administrator B provided TARs (Task Administration Records) for Resident 1.

The TAR contained daily charting titled "Monthly Activity Calander" which prompts for yes or no answers regarding the following two questions: "Were the Activities From the Daily Activity Calendar Offered to the Resident?" and "Did the Resident Participate in the Offered Calendar Activity?" The TAR included "instructions" to "Record activity offered and if they participated or not ...If the resident participated in activities beyond what was offered on the daily activities

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calendar, please note this in activity participation program."

The TAR did not contain documentation of the daily activity offered per facilities "instructions."

Resident 1's May, June and July TARs documented the following activities:

-- 82 "TV Program/Movie"
-- 24 "TV Program/Movie, Nap"
-- 9 "nap"
-- 6 "TV Program/Movie, Outing"
-- 6 "TV Program/Movie, Outside (as weather permits)"
-- 5 "Movies"
-- 5 "Ball Toss"
-- 3 "TV Program/Movie, Outing, Nap"
-- 2 "Sing-A-Long"
-- One (1) entry for each of the following activities:
* "TV Program/Movies, Outing Outside (as weather permits), Walking/exercise, Nap
* "TV Program/Movie, Board games"
* "Outside (as weather permits)
* "Sensory Stimulation"
* "Walking/exercise, Nap"
* "Music"

Surveyor noted the activities documented daily in the TARs did not align with the daily activities listed on the facilities activities calendar.

On 08/15/2024 at 2:00 PM, Surveyor interviewed Chief Executive Officer D, Case Management Director C, and Division Administrator B. Surveyor displayed the May 2024 TAR and scrolled through the multiple "TV Program/Movie" documented in "Activities - Participation Monitoring." Chief Executive Officer D, Case Management Director C, and Division Administrator B confirmed

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N 427	Continued From page 25 Surveyors review of the documentation and Case Management Director C stated there is a "yes and no question" that asks if the resident was offered the daily activity and whether they refused.	N 427		
Z 023	50.065(4m) (b) intro CAREGIVER HIRING AND CONTRACTING PROCESS Notwithstanding s.111.335, and except as provided in sub. (5), an entity may not hire or contract with a caregiver or permit to reside at the entity a nonclient resident if the entity knows or should have known any of the following: 1. That the person was convicted of a serious crime. 3. That a unit of government or a state agency, as defined in s. 16.61 (2) (d), has made a finding that the person has abused or neglected any client or misappropriated the property of any client. 4. That a determination has been made under s. 48.981 (3) (c) 4. that the person has abused or neglected a child. 5. That, in the case of a position for which the person must be credentialed by the Department of Safety and Professional Services, the person's credential is not current, or is limited so as to restrict the person from providing adequate care to the client.	Z 023		

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Z 023	Continued From page 26 This Rule is not met as evidenced by: Based on interview and record review, the provider permitted Caregiver A to work in the facility and have direct contact with residents, even though the caregiver had a finding of substantiated misappropriation of a client's property. Caregiver A did not have rehabilitation approval from the department to work as a caregiver. Findings include: The facility is licensed to provide services for up to 6 residents from the following client groups: Physically disabled, developmentally disabled, emotionally disturbed/mentally ill, irreversible dementia, Alzheimer's, and/or advanced age. On 07/29/2024 and 07/31/2024 the Department received complaints alleging abuse concerns. DQA publication P-00274 dated 07/2011 titled, Offenses Affecting Caregiver Eligibility for Chapter 50 Programs indicated, "...Unless the person is approved through the Rehabilitation Review process, the crimes and findings by government agencies included on the Offenses List (Tables I and II),...Employment as a caregiver with an entity is prohibited until rehabilitation approval is received for all programs and entities that serve only clients 18 years of age and older...Finding by a government agency of abuse or neglect of a client or of misappropriation of a client's property..." On 08/08/2024, Surveyor reviewed the personnel file of Caregiver A including staff roster, training, and background checks. Caregiver A was hired on 01/17/2024 as a Caregiver.	Z 023		

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(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
Z 023	Continued From page 27 The Integrated Background Information System (IBIS - caregiver background check for DHS findings) dated 01/17/2024 noted that Caregiver A had a finding dated 08/03/2023 of misappropriation of a client's property. The IBIS did not contain evidence that Caregiver A had successfully completed the Rehabilitation Review before working at the facility, as required by Chapter 50. On 08/15/2024 at 2:00 PM, Surveyor interviewed Chief Executive Officer D, Case Management Director C, and Division Administrator B via Teams regarding Caregiver A's background check. Chief Executive Officer D stated human resources and recruiters are responsible for hiring staff and reviewing the background checks. Division Administrator B confirmed that Caregiver A began employment as a caregiver in January 2024 and was transferred to another care facility within the last week, but could not recall the exact date. Chief Executive Officer D, Case Management Director C, and Division Administrator B acknowledged Caregiver A had not completed a Rehabilitation Review prior to being hired as a caregiver on 01/17/2024. On 08/15/2024, Chief Executive Officer D emailed Surveyor which included documentation of Caregiver A's employment termination. In summary: The provider permitted Caregiver A to work in the home for more than 6 months when Caregiver A had a finding of substantiated misappropriation of a client's property. The substantiated finding of misconduct prohibited Caregiver A to work as a caregiver in DHS regulated facilities in Wisconsin, unless approved under the rehabilitation review process.	Z 023		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013143	A. BUILDING: _____ B. WING _____	C 08/15/2024

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Z 023	Continued From page 28 Cross Reference: N0158 DHS 83.12(2)(a)2 Caregiver: Investigating Abuse and Neglect N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication	Z 023		