STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019926	A. BUILDING: _____ B. WING _____	C 07/22/2024

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A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

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N 000	Initial Comments On 07/10/2024, the Department conducted a complaint investigation at A Colfax Senior Living LLC. Data was collected through 07/22/2024. Three of 5 complaints were substantiated. Twelve deficiencies were identified. Census: 41	N 000		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure injuries of unknown origin were investigated. Resident 4 sustained unexplained injuries (skin tear) around 05/31/2024. Findings include: On 07/10/2024, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 04/26/2024, with diagnoses that included unstable burst fracture of T9-T10 vertebra, atherosclerotic heart disease, rheumatoid arthritis, chronic heart failure, and	N 161		

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

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N 161	Continued From page 1 unspecified dementia. Resident 4's observation notes, dated 05/31/2024, indicated Director of Nursing (DON) B observed a U-shaped skin tear on Resident 4's ring finger during a foot assessment. The observation note indicated a steri-strip was used to close the open area. On 07/18/2024 at approximately 12:30 PM, Surveyor interviewed DON B. Surveyor asked if there were any injury of unknown investigations for Resident 4. DON B stated there was 1 and s/he would send it to Surveyor. As of 07/22/2024, Surveyor did not receive documentation from DON B of an injury of unknown source investigation. The provider did not ensure all injuries of unknown origin were investigated.	N 161		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on interview and record review, the provider did not immediately notify Resident 1's	N 169		

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N 169	Continued From page 2	N 169		

legal representative and physician about significant changes in Resident 1's skin and pain level, or the development of multiple pressure injuries. The provider did not immediately notify Resident 2's physician when s/he experienced significant changes in his/her oxygen saturation and swelling in his/her legs.

Findings include:

RESIDENT 1
On 07/10/2024, Surveyor reviewed Resident 1's record.

Resident 1 was admitted on 05/09/2024 with multiple diagnoses, including: mild cognitive impairment, unspecified head injury, repeated falls, and unspecified disorientation. Resident 1 had an activated healthcare power of attorney (HCPOA).

On 05/10/2024, Director of Nursing (DON) B documented: "Resident's left torso assessed related to fall. No bruising noted to area over area [sic]. Skin is raised more than other side of [his/her] rib, resident does not complain of any pain when area is palpated."

On 05/17/2024, Resident 1 was sent to the emergency department. The after-visit summary in Resident 1's record contained the following instructions: "Give the antibiotic twice a day for 7 days. Encourage oral fluids. You can use lidocaine patches as prescribed on the tender area of the left rib (this is a fracture of the rib cartilage without any other complications such as bleeding)."

On 05/17/2024, the emergency department (ED)physician assistant documented the following

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note, in part: "[Resident 1] is a [age] [fe/male] presenting to the [ED] for evaluation of pain. Per [his/her] living facility they reported that the patient was complaining of increased pain on the left side after a fall a couple of weeks ago. Patient does have dementia with an activated power of attorney ...[S/he] does have dementia and is really not able to provide any specific information about where [s/he] is having pain. There is a deformity to the left anterior ribcage. There is some yellowing ecchymosis but no significant pain when I palpate over this area ... There is a mildly displaced fracture of the 8th rib costal cartilage which is likely the protuberance on his exam."

On 05/17/2024, the provider documented the following for Resident 1:

On 05/17/2024 at 6:40 a.m., Caregiver O documented an incident, which read: "Resident came crawling out of [his/her] room wondering where [s/he] could go to bed. No injury. Vitals taken. Resident's Room."

05/17/2024 at 9:04 a.m., Caregiver T documented: "resident [sic] was found crawling on the floor by [his/her] door, staff assisted [him/her] back to bed as requested."

There was no documentation to indicate what prompted the ED visit.

On 05/19/2024, Caregiver O documented: "When giving resident shower writer notice [sic] resident is getting some breakdown on upper buttocks. Applied cream."

On 05/31/2024, DON B documented: "Assessed resident's bottom. Area measuring 2 cm

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(centimeters) by 0.9 cm noted to coccyx area. Area does not appear open. Area non blanchable and at the top part of the area it is slightly purple. Resident did receive a new foam wheelchair cushion. Encourage repositioning and apply barrier cream to bottom with toileting. PCP (primary care physician) notified."

On 06/07/2024, Caregiver Q documented: "writer [sic] noticed a 2-3 inch blister on left heal [sic]. note [sic] left for DON."

On 06/12/2024, DON B documented a wound assessment on Resident 1's pressure injury to his/her coccyx and his/her left heel. S/he faxed Resident 1's physician with wound care measurements from Resident 1's pressure injury to his/her coccyx and pressure injury to his/her left heel. This was approximately 1 week after Caregiver Q documented observing the blister.

On 07/22/2024 at approximately 10:30 a.m., Surveyor interviewed Administrator A, DON B, Senior Vice President C, Vice President of Clinical Services D and Regional Nurse E. Surveyor asked what DON B meant when s/he documented Resident 1's skin was raised on 05/10/2024. DON B told Surveyor it was not an injury. S/he said, "One side looked different than the other side." DON B said it was not painful or bruised and s/he was unsure if it was normal. Surveyor asked DON B if s/he called Resident 1's legal representative to ask if this was normal. DON B replied, "I did not call family." Surveyor asked what happened on 05/17/2024 that Resident 1 was sent to the ED. DON B told Surveyor Resident 1 had a fall and was having increased pain. Surveyor asked if this was documented. DON B replied, "It does not appear to be documented." Surveyor asked if Resident

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N 169	Continued From page 5 1's legal representative was notified. DON B replied, "It does not appear to be documented." Surveyor asked when Resident 1's physician was first notified of the breakdown on Resident 1's buttocks. DON B said s/he notified the physician when s/he assessed Resident 1 on 05/31/2024. Surveyor requested documentation of the fax or orders Resident 1's physician prescribed. On 07/22/2024, Vice President of Clinical Services D emailed Surveyor a copy of a fax that House Manager F sent to Resident 1's physician on 06/03/2024, which read: "Resident has small pea size opening between the buttock cheeks at the bottom of the tailbone. We have been applying barrier cream and the area is now a hole approx. (approximately) 1/8 in (inch) deep. Can we get an order for something to treat this?" Surveyor reviewed Resident 1's medical record from his/her physician's office, and this fax, dated 06/03/2024,was the first documentation of notification to Resident 1's physician related to a pressure injury on Resident 1's coccyx. Surveyor asked DON B when Resident 1's physician was first notified of the pressure injury to Resident 1's heel. DON B told Surveyor, "Not until the 12th (06/12/2024)." Surveyor asked when s/he notified Resident 1's legal representative. DON B told Surveyor s/he was not sure when family was notified. The provider did not immediately notify Resident 1's legal representative and physician about significant changes in Resident 1's skin and pain level, or the development of multiple pressure injuries. RESIDENT 2 On 07/10/2024, Surveyor reviewed Resident 2's record.	N 169		

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N 169	Continued From page 6 Surveyor reviewed Resident 2's vital signs. Resident 2's oxygen saturations started trending down under 90% starting 05/31/2024 until 06/16/2024 when s/he was sent out to the Emergency Room. Resident 2 had 22 oxygen saturation reading below 90% between these days. Resident 2's observation notes also stated that on 04/08/2024, "Writer noticed legs were swollen. Writer asked [Resident 2] if they have been swollen like that for long. [S/he] said no, they normally aren't like that." There was no notation in the record that Resident 2's physician was notified of his/her changes in condition. On 07/18/2024 at approximately 12:30 p.m., Surveyor interviewed DON B. Surveyor asked DON B if Resident 2's physician was notified of Resident 2's decreasing oxygen saturation or swollen legs. DON B stated, "I don't believe so." Cross reference N0431 DHS 83.38(1)(g) Health Monitoring	N 169		
N 200	83.14(2)(e) Notify within 7 days of administrator change The licensee shall notify the department within 7 days after there is a change in the administrator. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not notify the Department within 7 days after a change in administrator. Findings include: On 07/08/2024, Surveyor reviewed the provider's	N 200		

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N 200	Continued From page 7 information with the Department which indicated Director of Nursing (DON) B was the administrator. On 07/10/2024 at 7:30 AM, Surveyors interviewed DON B. DON B stated s/he stepped down from the administrator position in May 2024. DON B was unsure if the provider notified the Department of the change. At 8:26 AM, the Department received an email from Administrator A indicating s/he was the provider's administrator. At 8:33 AM, Surveyors interviewed Administrator A. Administrator A stated s/he failed to report the change to the Department, and s/he sent the written notice in today. According to the provider's employee roster, Administrator A was hired on 05/06/2024.	N 200		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected.	N 214		

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N 214	Continued From page 8	N 214		

This Rule is not met as evidenced by:
Based on interview and record review, the provider did not ensure an administrator supervised the daily operation in a way that ensured residents received proper care and treatment, health services, safety, and rights were respected.

Findings include:

The provider is licensed to care for 58 residents the following client groups: physically disabled, emotionally disturbed/mental illness, traumatic brain injury, advanced aged, developmentally disabled, terminally ill, and irreversible dementia/Alzheimer's disease.

The licensee assumed operations in October 2023. The new license became effective on 02/22/2024. At this time, the provider named Director of Nursing (DON) B as the administrator responsible for the day-to-day operation of the program, a role DON B had been fulfilling at the location since 01/09/2023, according to the Department's records.

Between 05/08/2024 and 06/25/2024, the Department received 5 complaints related to resident care and treatment.

On 07/10/2024 at 7:30 AM, Surveyors interviewed DON B. DON B stated s/he stepped down from the administrator position in May 2024 when Administrator A was hired. DON B discussed being responsible for the daily operation and clinical services prior to Administrator A's hire. DON B stated the provider's organizational structure included Administrator A, DON B, house managers, lead caregivers, and caregivers.

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N 214	Continued From page 9 At 8:33 AM, Surveyors interviewed Administrator A. Administrator A stated DON B was responsible for the daily operation and all clinical services prior to May 2024. Around the end of May, Administrator A became responsible for the daily operation and DON B was able to focus just on clinical services. Administrator A said s/he received support from the provider's corporate team, which included Senior Vice President (VP) C, VP of Clinical Services D, and Regional Nurse E. According to the employee roster provided to Surveyors on 07/10/2024, Administrator A was hired on 05/06/2024. During the survey, 3 of the 5 complaints were substantiated, and the following issues were identified: - Residents' legal representatives and physicians were not notified when residents experienced incidents and changes. - Staff did not complete minimum training requirements. - Residents did not receive prompt and adequate care. - Residents were not assessed when they experienced changes in condition. - Service plans were not updated when residents experienced changes in condition and need. - Residents' health conditions were not monitored, and interventions were not provided to prevent emergency services. On 07/22/2024, Surveyors received an email from VP C that read, "I also wanted to inform you that due to areas of concern prior to your visit, [House Manager F] was placed on leave and since has been termed (terminated).	N 214		

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N 214	Continued From page 10 Based on the information that was shared, ... [DON B] has also been placed on leave pending investigation." Cross references: N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes N0230 DHS 83.19 Orientation N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses N0243 DHS 83.21(1)-(3) All Employee Training N0247 DHS 83.22(1)-(4) Task Specific Training N0353 DHS 83.32(3)(i) Rights Of Residents: Adequate Treatment N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0431 DHS 83.38(1)(g) Health Monitoring	N 214		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition.	N 230		

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N 230	Continued From page 11 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 staff sampled (Caregiver I, Caregiver J, and Caregiver K) completed orientation training. Findings include: The provider is licensed to care for 58 residents the following client groups: physically disabled, emotionally disturbed/mental illness, traumatic brain injury, advanced aged, developmentally disabled, terminally ill, and irreversible dementia/Alzheimer's disease. On 07/10/2024, Surveyor reviewed 3 employee records. Caregiver I was hired 04/18/2023 (hired prior to a change in ownership/licensure). Caregiver I's record did not include evidence of the following orientation trainings: Prevention and reporting of resident abuse, neglect and misappropriation of resident property; emergency and disaster plan and evacuation procedures; the provider's policies and procedures; or recognizing and responding to resident changes of condition. Caregiver J was hired on 01/24/2024. Caregiver J's record did not include evidence s/he completed training on the provider's emergency and disaster plan and evacuation procedures. Caregiver J's record indicated s/he completed orientation topics months after hire: - Prevention and reporting of resident abuse, neglect and misappropriation of resident property was completed on 06/21/2024. - Recognizing and responding to resident changes of condition was completed on 06/21/2024.	N 230		

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- Caregiver J's record included evidence s/he completed a training on the provider's documentation procedures on 05/23/2024. Training on the provider's policies and procedures was completed on 07/03/2024, over 5 months after hire.

Caregiver K was hired on 04/12/2024. Caregiver K's record did not include evidence s/he completed training on the provider's emergency and disaster plan and evacuation procedures. Caregiver K's record included evidence s/he completed a training on the provider's documentation procedures on 05/23/2024, and s/he completed training on the provider's policies and procedures on 07/03/2024, over 2 months after hire.

On 07/18/2024 at 10:30 AM, Surveyors interviewed Administrator A, Director of Nursing (DON) B, Senior Vice President (VP) C, Vice President of Clinical Services D, and Regional Nurse E. VP C stated s/he identified training concerns during an onsite visit in April 2024. VP C stated, "I realized there wasn't a training system so we transitioned [Administrative Assistant (AA) G] to training coordinator... [AA G] would keep staff on a training track... It was in June when we recognized an ongoing problem with compliance, and we hired an outside consultant... [Administrator A] has a deadline." VP C stated a previous nurse, Registered Nurse (RN) N, was the provider's trainer prior to the licensee change that occurred on 02/22/2024. VP C stated they believed RN N was going to continue this HR/trainer role, but this did not happen. VP C stated RN N's last day was 04/15/2024, and AA G took on the training coordinator role on 04/18/2024. DON B stated DON B was the administrator and responsible for training prior

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N 230	Continued From page 13 April 2024. DON B said there was no systematic training program to monitor employee training progress prior to April 2024.	N 230		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 staff sampled (Caregiver J) completed Department-approved standard precautions prior to assuming duties	N 239		

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A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

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that exposed him/her to bodily fluids, and s/he did not complete fire safety or first aid and choking within 90 days of hire.

Findings include:

The provider is licensed to care for 58 residents the following client groups: physically disabled, emotionally disturbed/mental illness, traumatic brain injury, advanced aged, developmentally disabled, terminally ill, and irreversible dementia/Alzheimer's disease.

On 07/10/2024, Surveyor reviewed 3 employee records. Caregiver J was hired on 01/24/2024. Caregiver J's record did not include evidence of training exemptions.

According to Caregiver J's training records and the Wisconsin Community-Based Care & Treatment Training Registry, Caregiver J completed standard precautions on 04/19/2024 and fire safety on 05/01/2024; s/he had not completed the first aid and choking course.

On 07/10/2024 at 11:16 AM, Surveyor interviewed Caregiver J. Caregiver J discussed his/her training and experience which did not include training exemptions for standard precautions, fire safety, or first aid and choking. Caregiver J stated s/he was promoted to lead caregiver about 2 weeks ago. As the lead, s/he was responsible for supporting and training caregivers.

Caregiver J discussed a burn incident that occurred on 06/22/2024 involving Resident 1. Caregiver J stated Resident 1 spilled hot coffee on his/her lap and started yelling, "It's hot! It's really hot! Its burning! My [genitals] are burning!" Caregiver J stated s/he rushed Resident 1 to

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N 239	Continued From page 15	N 239		

his/her room and assessed the injury. Resident 1's skin was blistered and red. After contacting the on-call manager and nurse, Caregiver J applied a cold compress. After contacting the family, Caregiver J applied A&D Ointment to the burned area.

Caregiver J did not follow standard first aid burn procedures, a topic s/he would have received training on during the Department-approved first aid and choking training course.

On 07/18/2024 at 10:30 AM, Surveyors interviewed Administrator A, Director of Nursing (DON) B, Senior Vice President (VP) C, Vice President of Clinical Services D, and Regional Nurse E. VP C stated s/he identified training concerns during an onsite visit in April 2024. VP C stated, "I realized there wasn't a training system, so we transitioned [Administrative Assistant (AA) G] to training coordinator... [AA G] would keep staff on a training track... It was in June when we recognized an ongoing problem with compliance, and we hired an outside consultant... [Administrator A] has a deadline." VP C stated a previous nurse, Registered Nurse (RN) N, was the provider's trainer prior to the licensee change that occurred on 02/22/2024. VP C stated they believed RN N was going to continue this HR/trainer role, but this did not happen. VP C stated RN N's last day with the company was 04/15/2024, and AA G took on the training coordinator role on 04/18/2024. DON B stated DON B was the administrator and responsible for training prior April 2024. DON B said there was no systematic training program to monitor employee training progress prior to April 2024.

Cross references:
N0353 DHS 83.32(3)(i) Rights Of Residents:

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N 239	Continued From page 16 Adequate Treatment	N 239		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious	N 243		

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N 243	Continued From page 17 behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 staff sampled (Caregiver J and Caregiver K) completed all-employee training within 90 days of hire. Caregiver J did not complete training on challenging behaviors, and s/he did not complete training on resident rights or the provider's client groups timely. Caregiver K did not complete training on challenging behaviors. Findings include: The provider is licensed to care for 58 residents in the following client groups: physically disabled, emotionally disturbed/mental illness, traumatic brain injury, advanced aged, developmentally disabled, terminally ill, and irreversible dementia/Alzheimer's disease. On 07/10/2024, Surveyor reviewed employee records. Caregiver J was hired on 01/24/2024 and Caregiver K was hired on 04/12/2024. Neither record included evidence of a training exemption or evidence of successful training completion on recognizing, preventing, managing, and responding to challenging behaviors.	N 243		

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N 243	Continued From page 18	N 243		

Caregiver J's record indicated s/he completed training on resident rights on 06/21/2024, and client group training on 06/20/2024, nearly 5 months after hire.

On 07/18/2024 at 10:30 AM, Surveyors interviewed Administrator A, Director of Nursing (DON) B, Senior Vice President (VP) C, Vice President of Clinical Services D, and Regional Nurse E. VP C stated s/he identified training concerns during an onsite visit in April 2024. VP C stated, "I realized there wasn't a training system, so we transitioned [Administrative Assistant (AA) G] to training coordinator... [AA G] would keep staff on a training track... It was in June when we recognized an ongoing problem with compliance, and we hired an outside consultant... [Administrator A] has a deadline." VP C stated a previous nurse, Registered Nurse (RN) N, was the provider's trainer prior to the licensee change that occurred on 02/22/2024. VP C stated they believed RN N was going to continue this HR/trainer role, but this did not happen. VP C stated RN N's last day with the company was 04/15/2024, and AA G took on the training coordinator role on 04/18/2024. DON B stated DON B was the administrator and responsible for training prior to April 2024. DON B said there was no systematic training program to monitor employee training progress prior to April 2024.

Surveyor discussed the training documentation provided during the survey and provided the management team a list of trainings missing from the employee records sampled. The team agreed to review their records and provide additional documentation by 10:00 AM on 07/19/2024.

As of 07/22/2024, the provider did not send documentation of the trainings listed above for

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N 243	Continued From page 19 Caregiver J and Caregiver K.	N 243		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation.	N 247		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 3 staff sampled (Caregiver J and Caregiver K) completed training on provisions of personal care prior to assuming job duties. Caregiver J and Caregiver K did not receive training on mobility and transferring until after assuming job responsibilities.

Findings include:

The provider is licensed to care for 58 residents in the following client groups: physically disabled, emotionally disturbed/mental illness, traumatic brain injury, advanced aged, developmentally disabled, terminally ill, and irreversible dementia/Alzheimer's disease.

On 05/01/2024, the Department received a self-report from the provider indicating Resident 6 sustained an injury from a fall after an improper transfer.

On 06/25/2024, the Department received a complaint related to transfer techniques.

On 07/10/2024, Surveyor reviewed employee records. Caregiver J was hired on 01/24/2024 and Caregiver K was hired on 04/12/2024. Neither record included evidence of a training exemption for the provision of care training requirement. Both caregivers completed training on mobility and transfers on 06/21/2024, approximately 5 months after Caregiver J was hired, and over 2 months after Caregiver K was

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N 247	Continued From page 21 hired. On 07/10/2024, Surveyor reviewed resident charting, which indicated Caregiver K assumed transferring duties prior to 06/21/2024 when s/he completed the training. Caregiver K wrote in Resident 1's notes on 05/10/2024, "Staff went to residents [sic] room, and resident was on he [sic] floor between bed and bathroom. We (Staff) got [him/her] back up in [his/her] wheelchair." On 07/18/2024 at 10:30 AM, Surveyors interviewed Administrator A, Director of Nursing (DON) B, Senior Vice President (VP) C, Vice President of Clinical Services D, and Regional Nurse E. VP C stated s/he identified training concerns during an onsite visit in April 2024. VP C stated, "I realized there wasn't a training system, so we transitioned [Administrative Assistant (AA) G] to training coordinator... [AA G] would keep staff on a training track... It was in June when we recognized an ongoing problem with compliance, and we hired an outside consultant... [Administrator A] has a deadline." VP C stated a previous nurse, Registered Nurse (RN) N, was the provider's trainer prior to the licensee change that occurred on 02/22/2024. VP C stated they believed RN N was going to continue this HR/trainer role, but this did not happen. VP C stated RN N's last day +was 04/15/2024, and AA G took on the training coordinator role on 04/18/2024. DON B stated DON B was the administrator and responsible for training prior April 2024. DON B said there was no systematic training program to monitor employee training progress prior to April 2024.	N 247		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment	N 353		

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N 353	Continued From page 22 In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 1 received prompt and adequate treatment after Resident 1 spilled coffee on him/herself and sustained a burn to his/her genital region and thighs. Findings include: On 06/25/2024, the Department received multiple complaints alleging a resident did not receive adequate care and services to meet his/her needs. On 06/25/2024, the Department received a self-report from the provider. The report read, in part: "[Resident 1] is a [age] year old [fe/male] residing in the care of Colfax Senior Living since 5/9/2024. [S/he] has diagnoses including dementia, spinal stenosis and kidney failure. On 6/22/2024 at approximately 1820 (6:20 p.m.) [Resident 1] requested and was given a cup of coffee by staff. [S/he] was observed to suddenly stop, tremor, and then spontaneously drop [his/her] coffee on [him/herself] spilling [his/her] coffee on [his/her] pants. Staff escorted [Resident 1] to the bathroom and provided immediate aid removing [his/her] pants, brief and providing care with cool cloths. Redness was noted to [his/her] bilateral thighs and 2 small blisters were formed, the RN (registered nurse) was notified and care instructions given... Staff continued to monitor	N 353		

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[Resident 1] through the night and updated the manager on duty, protocol for burns was followed and comfort maintained. The RN was notified the next morning around 10am [sic], the family was updated again and resident was seen by homecare RN for skin condition evaluation. [Resident 1] was sent to the ER (emergency room) and admitted for second degree burns... An investigation was immediately initiated and the coffee machines providing hot liquids have been modified to provide lower temperature coffee and hot water. [Resident 1's] family and MD (medical doctor) were updated accordingly and routine toileting was provided for [his/her] comfort and hygiene. RN and homecare were notified for further evaluation." The report was signed by Regional Nurse F.

On 07/10/2024, Surveyor reviewed the employee schedule. The schedule indicated Caregiver I and Caregiver J worked the unit where Resident 1 resided on the evening hours of 06/22/2024.

On 07/10/2024 at approximately 11:00 a.m., Surveyor interviewed Caregiver I on the phone. Caregiver I confirmed s/he was working the night Resident 1 spilled coffee on him/herself. S/he told Surveyor s/he did not observe Resident 1 spill the coffee as s/he was in the kitchen. S/he said Caregiver J was working and s/he saw it happen. S/he said they placed a cool compress on the area and removed Resident 1's pants and brief. S/he said Caregiver J called the on-call staff (Administrative Assistant (AA) G), Director of Nursing (DON) B, and Resident 1's family. Caregiver I said that within 10 minutes, the area was very red. S/he said it blistered right away. S/he said they continued their shift with applying cool compresses and a cream. Surveyor asked what type of cream they used. Caregiver I said,

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"I'm pretty sure it was udder balm." Caregiver I said they passed this information onto the next shift and documented Resident 1 had "severe burns" and to check on him/her periodically.

On 07/10/2024 at approximately 11:20 a.m., Surveyor interviewed AA G. AA G told Surveyor s/he received a call around 7:30 - 8:00 p.m. the night Resident 1 spilled coffee on him/herself. S/he said s/he did not document the call and the instructions given. S/he said s/he was not sure if s/he was told Resident 1 had blisters from the burn. S/he said s/he instructed staff to apply cool compresses and keep his/her pants open. S/he said s/he received another call at approximately 3:00 a.m. from Caregiver K. S/he said Caregiver K told him/her that Resident 1 had blood in his/her brief and a blister popped. AA G told Surveyor s/he thought the blood was from a sore on Resident 1's coccyx. AA G said s/he instructed Caregiver K to clean up Resident 1 and apply a bandage to Resident 1's coccyx. AA G said s/he came into work the next morning and observed Resident 1's burn. AA G said s/he was not expecting it to be that bad. AA G said s/he called DON B, Resident 1's home health nurse, and Resident 1's family. AA G said that when the home health nurse and Resident 1's family came in, they sent Resident 1 to the emergency department (ED). Surveyor asked AA G what staff were supposed to do if a resident burned themself. AA G said they should apply cold compresses. Surveyor asked if that is what s/he would do with a burn like Resident 1 had. AA G said, "I would go in, if it was that bad."

On 07/10/2024 at approximately 11:30 a.m., Surveyor interviewed Caregiver J on the phone. Caregiver J told Surveyor s/he was working the night Resident 1 spilled coffee and burned

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him/herself. S/he said Caregiver I brought Resident 1 to the table and gave him/her a cup of coffee. Caregiver J said s/he was at the medication cart and observed Resident 1 flip the cup toward him/herself and spill the coffee. Caregiver J said s/he immediately went to Resident 1 and took him/her to his/her room. Caregiver J said Resident 1 stated, "It's hot. It's really hot. It's burning. My [genitals] are burning!" Caregiver J said s/he called AA G who told Caregiver J to call DON B. Caregiver J said s/he called DON B and DON B instructed Caregiver J to apply cold compresses. Caregiver J said DON B instructed Caregiver J to call Resident 1's family. Caregiver J said s/he called Resident 1's health care power of attorney (HCPOA). Caregiver J said Resident 1's HCPOA said Resident 1 did not need to go to the hospital if Resident 1 was comfortable. S/he said Resident 1's HCPOA told Caregiver J to put burn cream on and A & D ointment. Caregiver J said s/he found some in the medication cart and applied it to Resident 1's burn. Caregiver J said Resident 1 reported that the burn felt better. Caregiver J said s/he let oncoming staff know and wrote down instructions for him/her. Caregiver J said, "I feel like I failed." Caregiver J explained that they were told to not send residents to the hospital without a nurse's permission. Caregiver J said s/he talked to Regional Nurse E about this, and Regional Nurse E told Caregiver J s/he could send residents to the ED without permission.

On 07/11/2024, Surveyor reviewed documentation on Resident 1 from the home health nurse, Home Health Registered Nurse (HHRN) L, with a visit date of 06/23/2024, visit time: 11:43 a.m. HHRN L documented: "PRN (as needed) visit due to facility calling at 1030 (10:30 a.m.) to report that patient had a BM (bowel

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movement) at 330 AM (3:30 a.m.) and disconnect [sic] [his/her] catheter from bag. They also reported approximately a 1 inch blister that was intact on the thigh and another blister that had opened up. They reported [s/he] spilled coffee in [his/her] legs yesterday did not report what time. On arrival patient was sitting at table grimacing POA was present with [family]. Patient was assisted into the bed with maximum 2 assist. Patient was moaning in pain. Once patient was placed in bed writer was able to see the blisters. Multiple intact blister [sic] present in bilateral groin with open areas of ruptured blisters. Are [sic] was 12 cm (centimeters) x 4 cm bilateral. Due to pain writer stopped assessment. Due to complexity of the burn area and pain it was recommended that patient seek ED evaluation ..."

On 07/11/2024, Surveyor reviewed documentation on Resident 1 from the hospital. Medical Doctor (MD) M documented, in part: "Patient is a [age] [fe/male] presenting to the emergency department from Colfax skilled nursing facility with burn to [his/her] genital and inguinal area. Burn secondary to hot liquid. On exam there is superficial partial- thickness burns throughout genital area including inguinal as [sic] and proximal medial thighs bilaterally. Patient will require further care. There is [sic] concerns about care received at [his/her] nursing facility given that patient has had multiple burn injuries since being a resident there. [S/he] also had delayed care as initially it was thought that only burn was too [sic] low abdomen, but this clearly involves the genital area." Date of service 06/23/2024 at 1:01 p.m.

On 07/22/2024 at approximately 10:30 a.m., Surveyor interviewed Administrator A, DON B, Senior Vice President C, Vice President of

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N 353	Continued From page 27 Clinical Services D, and Regional Nurse E. Surveyor reviewed Resident 1's burn incident on 06/22/2024. Surveyor asked if after they investigated the incident, they determined Resident 1 received prompt and adequate treatment for his/her burns. DON B told Surveyor "Treatment would have been sooner if I had been notified better on how the burns appeared." Surveyor asked if Resident 1 was provided any pain control such as Tylenol. DON B said s/he was reviewing Resident 1's medication administration record and told Surveyor Resident 1 did not receive any Tylenol. On 06/22/2024 at approximately 6:20 p.m., Resident 1 spilled hot coffee on him/herself, causing a burn that turned red and blistered to his/her groin and thighs. Resident 1 did not receive medical treatment until 06/23/2024 when HHRN L arrived at approximately 11:45 a.m. and determined Resident 1 needed to go to the ED. This was approximately 18 hours after the burn occurred. HHRN L noted Resident 1 was grimacing and moaning in pain. MD M noted Resident 1 had delayed care.	N 353		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission.	N 381		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not complete a comprehensive assessment after Resident 1 and Resident 3 had significant changes in condition.

Findings include:

RESIDENT 1
On 07/10/2024, Surveyor reviewed Resident 1's record.

Resident 1 was hospitalized prior to his/her admission to the facility from 04/12/2024 - 05/09/2024, when s/he discharged from the hospital to the facility.

On 05/09/2024, the hospital physician documented: "[age] [fe/male] with a history of cognitive impairment, spina bifida with gait instability and recurrent falls. [S/he] was admitted on 04/12/2024 after a [sic] unwitnessed fall at home. Pan trauma CT was negative for traumatic pathology. [S/he] was noted to have a UTI (urinary tract infection) and completed treatment for the same during this hospitalization. Also had urinary retention requiring Foley catheter placement which was successfully discontinued on 05/05/2024 with subsequent spontaneous voiding." The following diagnoses were listed by the physician:
"#1 Injury Head Initial
#2 Repeated Falls
#3 Confusion Chronic
1. Acute on chronic recurrent falls

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N 381	Continued From page 29 2. Major neurocognitive disorder senile with delirium 3. UTI without chronic indwelling Foley catheter 4. Urinary retention secondary to neurogenic bladder requiring in-hospital indwelling catheter removed 05/05/2024 5. Mild rhabdomyolysis" Resident 1's pre-admission assessment, dated 04/30/2024, indicated Resident 1 required assistance with repositioning, his/her skin condition was good with a note that read, "does have skin tear to left elbow and left hand related to fall at home." The assessment indicated Resident 1 had a catheter and was continent of bowels, with a note: "Some incontinence at home per family." History of urinary tract infection was not marked. Resident 1 was admitted on 05/09/2024 with multiple diagnoses, including: mild cognitive impairment, unspecified head injury, repeated falls, unspecified disorientation, and polyneuropathy (this is damage to nerves causing problems with sensation and coordination). On 05/17/2024, Resident 1 went to the emergency department (ED) and was diagnosed with acute cystitis, which is a urinary bladder infection. On 05/19/2024, staff documented Resident 1 had skin breakdown on his/her buttocks. On 05/31/2024, Director of Nursing (DON) B documented: "Assessed resident's bottom. Area measuring 2 cm (centimeters) by 0.9 cm noted to coccyx area. Area does not appear open. Area non blanchable and at the top part of the area is slightly purple.	N 381		

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Resident did receive a new foam wheelchair cushion. Encourage repositioning and apply barrier cream to bottom with toileting. PCP (primary care physician) notified."

Resident 1 did have a 30-day comprehensive assessment, dated 05/31/2024, which was the same date as DON B's note on Resident 1's wound. The assessment indicated Resident 1 was both independent and required assistance with repositioning. His/her skin condition was marked as good. This assessment indicated Resident 1 was incontinent of bladder, had a catheter, was continent of bowel and wore an incontinence pad/brief. This assessment did not indicate Resident 1's history of urinary tract infections.

Resident 1's 30-day comprehensive assessment did not indicate Resident 1 had skin breakdown to his/her buttocks. Resident 1's Foley catheter was removed prior to Resident 1's admission to the facility from the hospital.

On 06/07/2024, staff documented Resident 1 had a blister on his/her left heel, which was later identified as a suspected deep tissue pressure injury.

On 06/07/2024, staff documented Resident 1 was on the floor with no pants on covered in BM (bowel movement).

On 06/07/2024, Resident 1 went to the ED. S/he was diagnosed with pyelonephritis, urinary retention, a stage III pressure injury to his/her coccyx and cellulitis to the buttocks. Resident 1 returned to the facility with an indwelling urinary catheter.

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N 381	Continued From page 31 On 07/10/2024 at approximately 2:30 p.m., Surveyor interviewed DON B. Surveyor reviewed Resident 1's observation notes with DON B. DON B said s/he did not do a change in condition assessment for Resident 1. On 07/22/2024 at approximately 10:30 a.m., Surveyor interviewed Administrator A, DON B, Senior Vice President C, Vice President of Clinical Services D, and Regional Nurse E. Surveyor asked who completed Resident 1's assessment, dated 05/31/2024. DON B said House Manager (HM) F completed the assessment and s/he reviewed it. Surveyor asked if HM F or DON B physically assessed Resident 1 in person. DON B told Surveyor, "I know the residents." Surveyor reviewed Resident 1's skin condition was marked as good, even though DON B documented a wound note on the same date as the assessment, 05/31/2024. DON B confirmed the assessment was not accurate and said s/he must have missed that part. Resident 1 had significant changes in condition. S/he developed pressure injuries to his/her buttocks and heel. S/he was incontinent of urine, had multiple UTIs, and had urinary retention which subsequently led to having an indwelling catheter placed. Resident 1 also became incontinent of bowels. The provider did not do a comprehensive assessment when Resident 1 experienced several changes in condition. RESIDENT 3 On 07/10/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on 10/10/2023 and discharged to the hospital on 04/20/2024. According to his/her individual service plan (ISP),	N 381		

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updated 12/20/2023, Resident 3's primary diagnosis was anxiety. Resident 3's diagnostic list also included diabetes, chronic kidney disease, a history of vitamin deficiencies, irritable bowel syndrome with chronic diarrhea, and major depressive disorder.

Staff care charting and observation notes from April 2024 indicated Resident 3 had a significant change in condition. Changes noted included increased anxiety, isolation, refusing food and drink for fear of needing to go to the bathroom, weight gain, and decreased physical activity.

The last documented assessment in Resident 3's record was dated 02/16/2024. This was a Braden Scale assessment which indicated Resident 3 was not at risk for pressure injuries. Resident 3's last nutritional assessment on file was dated 11/20/2023, which indicated Resident 3 was not risk for malnutrition. Resident 3's last pain assessment was dated 11/20/2023 and read, "Resident is not at risk for pain; do not proceed with care planning."

On 07/18/2024, Surveyor received an after-visit summary report (AVS), dated 04/18/2024, that read, in part: "[Resident 3] is complaining of significant pain in the buttock and has redeveloped but [sic] sores ... [S/he] has [sic] not eating or drinking well at all because of the pain and not wanting to go to the bathroom. It is most painful when [s/he] shifts position on [his/her] buttocks ... [s/he] has shear pressure sores on both medial buttocks in a symmetrical pattern ... Under [his/her] skin folds [s/he] has tinea corporis but no skin breakdown ... Pressure Injury (Ulcer) Of Right Buttock Stage 2 ... The big issue here is pressure. [S/he] does not need even the Mepilex boarder. They need to stop using the thick pad. If

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[s/he] does not care for the Desitin on [his/her] clothing, [s/he] should just use depends [sic]. I did refer to home health care and OT (occupational therapy) and PT (physical therapy) for assistance with mainly positioning and increasing activity. I think the skin issue will actually heal up very quickly." Resident 3's physician ordered acetaminophen 1000 mg 3 times a day for buttock pain and clotrimazole 1%, apply 2 times per day to clean and dry skin underneath abdominal folds until rash clears.

On 07/18/2024 at 10:30 AM, Surveyors interviewed Administrator A, DON B, Senior Vice President (VP) C, Vice President of Clinical Services D, and Regional Nurse E. Surveyor asked about the provider's assessment policy. VP C stated residents should be assessed prior to admission, within 30 days of admission, every 6 months, and as needed. VP C stated s/he expected assessments to occur when a resident experienced a change in condition, after a fall, after a hospital admission, or for skin concerns, such as wounds. VP C stated the timing and type of assessment depended on the situation and the nurse's clinical judgement. VP C stated that if a resident's eating pattern changed, s/he might expect the nurse to review charting and consult with dietary. VP C stated DON B was responsible for assessments. VP C stated DON B was acting as the administrator as well as the provider's nurse until May 2024, but s/he was still responsible for assessment during this time. VP C stated they created the house manager role to assist with data collection; the house manager positions were filled on 03/13/2024.

Surveyor asked if the provider assessed Resident 3 in April 2024. VP C stated Resident 3 was assessed by physical therapy on 04/16/2024. VP

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C stated the provider did not have a copy of the assessment, but if therapy had any concerns, they would have reported it to DON B. DON B could not recall if there were any concerns noted during the assessment. Surveyor asked if the concerns were documented anywhere and DON B replied, "Probably not."

Surveyor reviewed Resident 3's progress notes from 04/11/2024 to 04/17/2024, which referenced Resident 3's increased anxiety, isolation, change in diet, and fear of falling and asked if these observed changes should have resulted in an assessment. DON B stated the observations "wouldn't necessarily trigger an assessment ... I talked to [Resident 3] quite a few times, but I guess I didn't document it." VP C stated, "[Resident 3] should have had a full assessment ... [His/her] care plan should have reflected a behavior plan for anxiety, skin breakdown ... there wasn't the right clinical follow up."

On 07/19/2024, Surveyor received a copy of the fax notification sent to Resident 3's physician on 04/12/2024, from VP C. The fax read, "Resident seems to be having increase [sic] anxiety, shaking, unsure what to do but not really able to tell us what the matter is. [His/her] vitals have been checked; all are within normal range. Resident is isolating [him/herself] in [his/her] room and skipping meals. I have included [his/her] med list for you to look over and see what changes, if any, can be made... [HM F]." Resident 3's physician responded, "Patient should be seen to assess med changes."

The provider did not assess Resident 3 when Resident 3 experienced a change in condition in April 2024. Staff documented changes to Resident 3's anxiety, eating, voiding, social

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N 381	Continued From page 35 isolation, and shakiness. The provider contacted Resident 3's physician on 04/12/2024 and acknowledged Resident 3 was unable to tell them what was wrong, but they did not complete a comprehensive assessment to determine the source of the change. Cross reference: N0431 DHS 83.38(1)(g) Health Monitoring	N 381		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 5 individual service plans (ISP) reviewed (Resident 1, Resident 2, and Resident 4) were updated with changes in condition. Findings include: The provider is licensed to care for 58 residents	N 389		

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in the client groups: irreversible dementia/Alzheimer's disease, developmentally disabled, terminally ill, traumatic brain injury, advanced age, physically disabled, and emotionally disturbed/mental illness.

RESIDENT 1
On 07/10/2024, Surveyor reviewed Resident 1's record.

Resident 1 was admitted on 05/09/2024 with multiple diagnoses including: mild cognitive impairment unspecified head injury, repeated falls, unspecified disorientation, and polyneuropathy (damage to nerves causing problems with sensation and coordination).

Resident 1's ISP, signed by Administrator A and Director of Nursing (DON) B on 05/24/2024 contained the following goals and interventions:

Need - "Repositioning Assistance"
Goal - "Resident's repositioning needs will be accommodated."
Intervention - "Staff will offer assistance when physically repositioning the resident is required."

Need - "Skin Condition"
Goal - "Resident's skin condition will be monitored."
Interventions - "Staff will be aware of resident's skin condition. Any changes in skin (rashes, redness, open areas, non-blanchable areas, color) to be reported to Nurse [sic]. Skin assessment to be completed weekly with shower/bath. See skin care protocol."
Note - "does have a skin tear to left elbow and left hand related to fall at home."

Need - "Eating Assistance"

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Goal - "Resident's eating needs will be addressed by staff."
Intervention - "Staff will help the resident prepare, orient, and eat their meals during the specified times of day."
Note - "Set resident up for meals. May require some assistance. Resident's favorite food is mashed potatoes and gravy."

EATING ASSISTANCE
On 05/15/2024, staff documented: "At 6:27 PM resident was drinking a hot cup of coffee at the dinner table. [S/he] lost [his/her] grip on it and it spilled on top of [his/her] left foot ..."

Resident 1's comprehensive ISP did not reflect this incident or interventions to prevent this from happening again.

On 06/22/2024, DON B documented: "Writer notified that resident spilled coffee on [him/herself] while at the table. Caregiver told writer that resident's pants were removed and there was [sic] 2 small blisters on resident's groin. Writer notified care giver [sic] to put cold compresses on area. Burn did not affect resident's genitals per caregiver and resident was not in pain or discomfort. Caregiver instructed to have resident use lids for [his/her] coffee. Monitor for increased pain or discomfort. Monitor for more blistering or redness to area and notify if blisters get worse/bigger."

On 06/23/2024, Home Health Registered Nurse (HHRN) L visited Resident 1 at 11:43 a.m. S/he documented the following note, in part: "They also reported approximately a 1 inch blister that was intact on the thigh and another blister that had opened up. They reported [s/he] spilled coffee in [sic] [his/her] legs yesterday and did not

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report what time. On arrival patient was sitting at table grimacing [sic] POA (power of attorney) was present with [family]. Patient was assisted into the bed with maximum 2 assist. Patient was moaning in pain. Once patient was placed in bed writer was able to see the blisters. Multiple intact blister [sic] present in bilateral groin with opens [sic] area of ruptured blisters. Are [sic] was 12 cm (centimeters) x 4 cm bilateral. Due to pain writer stopped assessment. Due to the complexity of the burn area and pain it was recommended that patient seek ED (emergency department) evaluation ...EMS (emergency medical services) services requested. [Family] expressed concerns due to this being the third time [s/he] has spilled coffee on [him/herself] and had residual effects, this being the most extreme ..."

On 06/23/2024, Resident 1 was sent to the emergency department for the scald burn. Documentation by Medical Doctor M, dated 06/23/2024, read, in part: "Patient is a [age] [fe/male] presenting to the emergency department from Colfax skilled nursing facility with burn to [his/her] genital and inguinal area. Burn secondary to hot liquid. On exam there is superficial partial-thickness burns throughout genital area including inguinal as [sic] and proximal medial thighs bilaterally. Patient will require further care. There is [sic] concerns about care received at nursing facility given that patient had multiple burn injuries since being there. [S/he] also had delayed care as initially it was thought that only burn was too [sic] abdomen, but this clearly involves the genital area."

On 07/22/2024 at approximately 10:30 a.m., Surveyor interviewed Administrator A, DON B, Senior Vice President (VP) C, Vice President of Clinical Services (VPCS) D and Regional Nurse

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N 389	Continued From page 39 (RN) E. Surveyor asked who was responsible for updating Resident 1's ISP. DON B said House Manager (HM) F was. Surveyor asked if Resident 1's ISP should have been updated with interventions after Resident 1 spilled hot coffee on him/herself on 05/15/2024 to prevent reoccurrence. DON B told Surveyor the ISP should have been updated. SKIN/REPOSITIONING On 05/19/2024 and 05/22/2024, staff documented Resident 1 had breakdown on his/her buttocks. On 05/31/2024, DON B documented: "Assessed resident's bottom. Area measuring 2 cm (centimeters) by 0.9 cm noted to coccyx area ... Resident did receive a new foam wheelchair cushion. Encourage repositioning and apply barrier cream to bottom with toileting ..." Resident 1's ISP was not updated to reflect this change in Resident 1's skin with interventions to promote healing. On 06/02/2024, HM F documented Resident 1 had a small open area on the buttocks. On 06/07/2024, staff documented Resident 1 had a 2 3-inch blister on his/her left heel. On 06/10/2024, Staff P documented: "Pt (patient) was given a waffle cushion with pillowcase cover for sore bottom ... For now, please use the waffle cushion to prevent further skin abnormalities." This intervention was not added to Resident 1's ISP. On 06/12/2024, DON B documented a wound assessment for Resident 1's coccyx and heel.	N 389		

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N 389	Continued From page 40 S/he listed the following treatments for the coccyx wounds: "Mepilex dressing twice per day, encourage repositioning, wheelchair cushion." Treatment for the heel pressure injury included: "heel protectors, elevate feet off bed." These interventions were not added to Resident 1's ISP. On 06/21/2024, Home Health Registered Nurse (HHRN) S documented Resident 1's wound to the coccyx as a stage III pressure injury, measuring 8 cm in length, 7 cm in width, and 0.4 cm in depth. The wound had scant drainage described as "Serosanguineous: Thin, Pale Red/Pink, Watery." HHRN S documented the wound to Resident 1's left heel was a suspected deep tissue pressure injury. It was a closed area measuring 2.9 cm in length, 1.5 cm in width and no depth. On 06/23/2024, HHRN L noted 2 additional pressure injuries. Documentation included: "On assessment writer note [sic] redness on the outer left knee that did not blanch and a pressure injury on the right ankle from button from catheter bag ..." On 07/22/2024 at approximately 10:30 a.m., Surveyor interviewed Administrator A, DON B, Senior Vice President C, Vice President of Clinical Services D and Regional Nurse E. Surveyor asked what interventions were updated to Resident 1's ISP related to his/her pressure injuries. DON B said they did add to Resident 1's care plan to reposition every 2 hours. DON B confirmed the ISP should have been updated to reflect Resident 1 had pressure injuries and confirmed it was not updated.	N 389		

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RESIDENT 3
On 07/10/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on 10/10/2023 and discharged to the hospital on 04/20/2024.

On 07/10/2024, Surveyor requested all assessments, communication with Resident 3's physicians, and medical summaries for Resident 3 from Administrator A and DON B. The following timeline was created based on these documents:
- 11/20/2023 - The provider completed the Frontida Fall Risk Assessment, which rated Resident 3 as a moderate fall risk. The provider also completed the Mini Nutritional Assessment, which indicated Resident 3 was at risk for malnutrition, and a risk assessment tool which indicated Resident 3 was not at risk for choking, elopements, or pain.
- 12/04/2023 - Resident 3 had a follow up appointment with his/her physician to address a pressure injury on his/her right buttock. The appointment summary read, "Pressure injury on right buttock has improved. Erythema is now blanchable. Recommend [s/he] continue to have zinc oxide applied twice a day ...discussed the importance of getting up to offload the pressure and ambulate ...[S/he] may benefit from seeing memory clinic."
- 12/05/2023 - The provider completed the Saint Louis University Mental Status (SLUMS) evaluation which indicated Resident 3 had mild cognitive impairment.
- 01/05/2024 - Resident 3's home health program provided wound care and documented his/her pressure injury was in the healing process.
- 01/22/2024 - Resident 3 had a diabetic check-up. The document indicated Resident 3 should continue a low carb diet. A handwritten note from the physician read, "Continue with zinc

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oxide to buttocks 2x day. Left buttock pressure injury is healed. Right buttock pressure injury has eschar present yet."
- 02/15/2024 - Resident 3 was seen at the emergency department for tremors and anxiety.
- 02/16/2024 - The provider completed a Braden Scale assessment which indicated Resident 3 was not at risk for pressure injuries. The assessment documented Resident 3 walked frequently (defined as getting up and walking around at least 1 time every 2 hours) and had adequate nutritional intake (defined as eating over ½ of most meals and eating a total of 4 servings of protein per day).

Resident 3's Social History and Activity Interest Survey (undated) read, "Severe anxiety, memory loss/confusion/cognitive issues. Hospitalized recently with malnutrition ... What is most important to you while you are receiving care here? Feel better without shaking so I can participate in activities."

Based on staff daily charting, Resident 3 experienced a significant change in condition between 04/11/2024 and 04/20/2024, that was marked by increased anxiety, isolation, refusing to eat or drink for fear of needing to use the bathroom, and decreased physical activity. Staff progress notes read:
04/15/2024 - "Staff came and got writer and stated that resident was shaking and breathing heavy. Writer went and seen [sic] resident and writer had seen resident like this once before and knew that [his/her] anxiety was high again and so writer sat with resident and talked with [him/her] to find out what was wrong. Resident stated that [s/he] was scared that [s/he] was going to fall if [s/he] got up to go [sic] the bathroom, so writer told [him/her] to ring for help whenever [s/he] had

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to go and that we would help [him/her] and resident stated then that [s/he] was scared that if [s/he] went to the bathroom that the pad on [his/her] butt would fall off so writer assured [him/her] that we had more and that we could fix it. Also, remined [Resident 3] that [s/he] had a MD appointment on Thursday to go over [his/her] meds. Writer told RN about what was happening with resident. Family was updated via email."

04/17/2024 - "Staff had came [sic] and got writer again and was told that resident had not come out of [his/her] room yet and that [s/he] has not been eating very much. Writer went and seen [sic] resident and resident was upset and scared again over falling and if [s/he] ate or drank that [s/he] would have to go to the bathroom, writer reminded [him/her] what we had talked about 2 days prior [sic] resident stated that [s/he] remembered but is afraid that nobody will come because they will be busy. Resident repeated what [s/he] had said to writer days prior, so writer wrote up a little sign that stated that [s/he] could ring for help and we will come and help [him/her] [sic] that if the patch falls off we can replace it, that if [s/he] didn't eat or drink that our bodies get undernourished and we become dehydrated and weak. And that if all we do is sit in the chair that our butt gets sore and could cause our skin to break down, so we need to eat to stay healthy and feel better. Resident liked the sign that writer made and resident did order French toast of [sic] the alternative menu to eat and had a protein shake as well. Writer reported this to the nurse."

Resident 3's ISP, updated 12/20/2023, indicated Resident 3's primary diagnosis was anxiety. Resident 3's diagnostic list also included diabetes, chronic kidney disease, a history of vitamin deficiencies, irritable bowel syndrome with

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chronic diarrhea, and major depressive disorder.

Resident 3's ISP read:
"Resident will transfer independently and safely ... Staff will ensure resident transfers independently and safely." The ISP did not reference Resident 3's need for occasional staff assistance.

"Resident to eat a regular diet ... Staff will ensure that resident maintains a regular diet." The ISP did not reference Resident 3's need for a low carb diet, history of malnutrition, or what to do in response to changes in Resident 3's nutritional intake.

"Resident's skin condition will be monitored ... Staff will be aware of resident's skin condition ... Any changes in skin (rashes, redness, open areas, non-blanchable areas, color) to be reported to Nurse." Resident 3's ISP did not reference his/her history of skin breakdown or interventions to prevent breakdown.

"Mental Health Status ...Good" The ISP did not include reference to Resident 3's cognitive impairment.

"Staff to provide behavior intervention for resident based on their unique needs ... Standard interventions:1. Allow resident to validate concerns. 2. Encourage resident to use bathroom to relieve bowel and bladder (Ask or check when last BM occurred, if possible). 3. Offer fluids. 4. Assess resident for pain/discomfort. 5. Involve resident in activity appropriate for cognition level. 5. Let resident continue if there are not adverse consequences to self or others." The ISP did not include information about Resident 3's mental health needs or interventions to assist with his/her anxiety.

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N 389	Continued From page 45 The provider did not update Resident 3's ISP when s/he experienced a change in condition or need. On 07/18/2024 at 10:30 AM, Surveyors interviewed Administrator A, DON B, VP C, VPCS D, and RN E. Surveyor asked who was responsible for updating ISPs and ensuring care plan accuracy. Regional Nurse E stated the facility nurse (DON B) was responsible. Regional Nurse E stated house managers were able to make changes to ISPs also, and house managers were responsible to ensure appropriate care tasks were scheduled. Surveyor reviewed Resident 3's progress notes from 04/11/2024 to 04/17/2024 with the management team which referenced Resident 3's increased anxiety, isolation, change in diet, and fear of falling and asked if these observed changes should have resulted in an assessment. VP C stated, "[Resident 3] should have had a full assessment ... [His/her] care plan should have reflected a behavior plan for anxiety, skin breakdown ... there wasn't the right clinical follow up." RESIDENT 4 On 07/10/2024, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 04/26/2024, with diagnoses that included unstable burst fracture of T9-T10 vertebra, atherosclerotic heart disease, rheumatoid arthritis, chronic heart failure, and unspecified dementia. Resident 4's record included one ISP dated 05/28/2024 which read:	N 389		

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Transfer assistance - "Resident's transfer needs will be accommodated. Staff will offer physical assistance when transferring the resident." Toileting - "Resident will receive assistance with toileting, one staff to provide toileting assistance."

An activity evaluation completed on 04/26/2024 indicated Resident 4 was independent with wheelchair.

On 07/10/2024 at approximately 8:00 AM, Surveyor observed a typed note posted on Resident 4's closet that read: "If [Resident 4] is unable to do a proper stand pivot transfer. [sic] Please use a Hoyer lift due to compression fractures. Do not use sit to stand mechanical lift at this time. Any other questions please reach out to therapy." The note also included a handwritten comment that read, "*2 person pivot*."

On 7/18/2024 at approximately 12:45 PM, Surveyors interviewed DON B regarding Resident 4's transfer status. DON B stated that his/her care plan indicated Resident 4 needed assistance of 1; DON B stated, "It has always been this way." Surveyor discussed observing a note in Resident 4's room on 07/10/2024 indicating s/he required different assistance. DON B stated s/he was unaware of the note in Resident 4's room and stated s/he believed Resident 4 had always required 1-assist with transfers. Surveyor referenced the activity assessment that indicated Resident 4 was independent. DON B stated s/he does not believe it is accurate as the Activites Director is not trained to assess transfer status.

Resident 4's ISP dated 5/28/2024 read under fall prevention program: "Resident to be free from serious injury related to falls. Staff to provide extensive assistance to resident to prevent falls."

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N 389	Continued From page 47 Surveyors reviewed Resident 4's observation notes. On 05/13/2024 and 06/20/2024 staff noted that Resident 4 had unwitnessed falls. The 06/20/2024 observation note stated Resident 4 reported hitting his/her head and had pain in his/her right thumb. On 6/21/2024 and 6/22/2024 staff noted the resident was starting to become confused and screaming out. Surveyors interviewed DON B, and asked what was put in place after Resident 4's falls to prevent future falls. DON B stated they put roller blocks on the wheelchair. Surveyor asked how this was communicated to staff. DON B stated, "I let our maintenance man know." When asked how it was communicated to caregiving staff s/he stated, "It should have been updated on the care plan." VP C stated that after a fall the nurse should complete an assessment the following business day. VP C stated the provider's fall policy included how to follow-up on a fall, incident reporting, and added interventions. VP C said any fall should be discussed with the regional team, and notes should be sent to the regional nurse. VP C stated, "It appears there is a failure in that process." Cross References: N0431 DHS 83.38(1)(g) Health Monitoring	N 389		
N 431	83.38(1)(g) Health monitoring. 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: Health	N 431		

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monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 1, Resident 2, Resident 3, and Resident 5, received health monitoring to meet their needs.

Findings include:

The Department received multiple complaints related to the resident care and treatment.

The provider is licensed to care for 58 residents

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in the following client groups: physically disabled, emotionally disturbed/mental illness, traumatic brain injury, advanced aged, developmentally disabled, terminally ill, and irreversible dementia/Alzheimer's disease.

RESIDENT 1

The National Pressure Injury Advisory Panel defines a pressure injury as: "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue."

On 07/10/2024, Surveyor reviewed Resident 1's record.

Resident 1's pre-admission assessment, dated 04/30/2024, indicated Resident 1 required assistance with repositioning. His/Her skin condition was good, with a note that read, "does have skin tear to left elbow and left hand related to fall at home."

Resident 1 was admitted on 05/09/2024 with multiple diagnoses, including mild cognitive impairment unspecified head injury, repeated falls, unspecified disorientation, and polyneuropathy (damage to nerves causing problems with sensation and coordination).

A Braden Scale assessment, dated 05/14/2024, signed by Director of Nursing (DON) B, indicated

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N 431	Continued From page 50 Resident 1 was at risk for skin breakdown. Resident 1's individual service plan (ISP), signed on 05/24/2024 by DON B and Administrator A, read, in part: "Resident's repositioning needs will be accommodated." Interventions included: "Staff will offer assistance when physically repositioning the resident is required." ...Resident's skin condition will be monitored." Interventions included: "Staff will be aware of resident's skin condition. Any changes in skin (rashes, redness, open areas, non-blanchable areas, color) to be reported to Nurse [sic]. Skin assessment to be completed weekly with shower/bath ... does have a skin tear to left elbow and left hand related to fall at home." Resident 1's ISP did not indicate s/he was at risk for skin breakdown per his/her Braden skin assessment. Resident 1 had the following care plans: 05/13/2024 - "Repositioning Assistance assist of one ...Skin Condition does have a skin tear to left elbow and left hand related to fall at home." 05/24/2024 - "Repositioning Assistance assist of one ...Skin Condition does have a skin tear to left elbow and left hand related to fall at home." 05/26/2024 - "Repositioning Assistance assist of one ...Skin Condition does have a skin tear to left elbow and left hand related to fall at home." 06/02/2024 - "Repositioning Assistance assist of one ...Skin Condition does have a skin tear to left elbow and left hand related to fall at home." 06/07/2024 - "Repositioning Assistance assist of one ...Skin Condition does have a skin tear to left elbow and left hand related to fall at home." 06/09/2024 - "Repositioning Assistance assist of one ...Skin Condition does have a skin tear to left elbow and left hand related to fall at home ...	N 431		

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Repositioning Assistance Place wedges under resident while [s/he] is in bed at night. Rotate every 2 hours."

Resident 1's weekly skin condition assessments were marked as completed on the following dates: 05/15/2024, 05/22/2024, 05/29/2024, 06/05/2024, 06/12/2024, and 06/19/2024. There was no documentation on the weekly assessments to indicate the condition of Resident 1's skin.

On 05/19/2024, Caregiver O documented, "When giving resident shower writer notice [sic] resident is getting some breakdown on upper buttocks. Applied cream."

On 05/22/2024, Caregiver O documented, "Resident has some breakdown on buttocks, applied cream."

On 05/31/2024, DON B documented, "Assessed resident's bottom. Area measuring 2 cm (centimeters) by 0.9 cm noted to coccyx area. Area does not appear open. Area non blanchable and at the top part of the area is slightly purple. Resident did receive a new foam wheelchair cushion. Encourage repositioning and apply barrier cream to bottom with toileting. PCP (primary care physician) notified."

On 07/10/2024 at approximately 2:30 PM, Surveyor interviewed, and reviewed Resident 1's observation notes, with DON B. DON B told Surveyor s/he first assessed Resident 1's bottom on 05/31/2024. Surveyor asked if Resident 1's wound was a pressure injury. DON B confirmed to Surveyor it was a pressure injury. DON B told Surveyor s/he did not stage the pressure injury. DON B said s/he did not do a change in condition

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assessment for Resident 1.

Resident 1 did have a 30-day comprehensive assessment, dated 05/31/2024, which was the same date as DON B's note on Resident 1's coccyx wound. The assessment indicated Resident 1 was both independent and required assistance with repositioning. His/her skin condition was marked as "good," with the following note: "does have a skin tear to left elbow and left hand related to fall at home." This was the same note that was in Resident 1's pre-admission assessment, dated 04/30/2024.

On 06/02/2024, HM F documented:, "Resident has a small open area on [his/her] right buttocks. Contacted facility nurse per [his/her] instructions, apply barrier cream every incontinence/bathroom and encourage repositioning."

On 06/03/2024 at 10:32 AM., Staff P documented: "Resident was given a shower by therapy. Resident has an open sore on buttocks that required gauze/padded dressing. Therapy communicated with house manager, and [s/he] will reach out to family to request patient gets a ROHO cushion (brand of pressure relief cushion). No other skin concerns during therapy/bathing session."

On 06/03/2024 at 12:28 PM, HM F faxed Resident 1's PCP. The fax read:, "Resident has a small pea size opening between the buttock cheeks at the bottom of the tailbone. We have been applying barrier cream and the area is now a hole approx. (approximately) 1/8 in (inch) deep. Can we get an order for something to treat this?"

This is the first documentation of a fax to Resident 1's PCP, which was approximately 2

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weeks after staff originally documented Resident 1 was having skin breakdown on his/her buttocks.

On 06/07/2024 at 5:40 AM., Caregiver Q documented: "writer [sic] noticed a 2-3 inch blister on left heal [sic]. note [sic] left for DON."

An incident report dated 06/07/2024 at 6:45 AM., by Caregiver R, read:, "Resident was found on floor outside of bedroom door / dining room with no pants and covered in BM (bowel movement). Screamed in pain anytime [s/he] was touched, slightly moved, or upon trying to move [him/herself]... Cried to writer that [s/he] was in pain and could not move, did not want to be touched. Nurse advised staff to have resident sent out, so called 911, family, and got resident cleaned up and checked vitals while waiting. Resident sent out around 7:30am [sic] and returned back at lunch time [sic]. Family contacted. Staff made statements of incident HM (house manager) with After Visit Summary."

Documentation from Resident 1's emergency room (ER) visit on 06/07/2024 indicated Resident 1 was diagnosed with pyelonephritis (urinary tract and kidney infection), urinary retention, pressure injury to the sacral region, and cellulitis (skin infection) in his/her buttocks. Documentation for the wound note indicated Resident 1 had a stage III pressure injury to the coccyx. It was 2 cm wide by 2 cm long. Signs of infection included erythema (redness), pain, and drainage. The wound bed was described as "Shiny; Fibrin/Slough." The after-visit summary included directions for the following antibiotics that were ordered for Resident 1, with instructions to pick up the medications from the pharmacy: cefdinir 300 mg (milligrams), by mouth, 2 times a day before breakfast and dinner for 10 days and

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doxycycline monohydrate 100 mg, by mouth, 2 times day before breakfast and dinner for 10 days.

On 06/07/2024 at 4:01 PM, HM F documented: "Writer had received orders from resident's ER visit. Faxed to primary MD to get referral for wound care and catheter care. Primary MD (medical doctor) sent fax granting catheter care and wound care referral."

The fax, dated 06/07/2024, read, "Resident had a fall this morning and now has a catheter. So, can I get a referral for home health to manage the catheter or urology? Also, you will see that in the orders for [sic] from the ER [s/he] is to see you in one week, is there a way I can get an appointment on or around the 14th of June? Please note the orders from the ER as well. Along with wound care. Fall happened this morning. PLEASE SEND NEW SCRIPT TO HEALTH DIRECT PHARMACY TO REFLECT ANY MEDICATION CHANGES."

On 06/07/2024, Resident 1's PCP returned a fax with orders from the fax HM F sent on 06/03/2024. The fax included the following orders: "Cleanse or irrigate with each dressing change daily. Try to redistribute pressure from the area as much as possible. Could do mepilex [sic] dressing-sacral padding to help. Do you want referral to wound care?"

Resident 1's medication administration record (MAR) indicated the Mepilex dressing was not started until 06/16/2024.

On 06/10/2024, Staff P documented: "Pt (patient) was given a waffle cushion with pillowcase cover for sore bottom. The ROHO cushion [s/he] was

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given by staff does not work. Communicated with HM and [s/he] will talk to family to get a ROHO cushion ordered as soon as they can. For now, please use the waffle cushion to prevent further skin abnormalities."

On 06/11/2024, HM F documented: "Received signed orders from primary MD. Emailed them to pharmacy."

Resident 1's record from his/her primary physician's office documented the following telephone encounter on 06/11/2024:
"SITUATION: Med (medication) Question ASSESSMENT [name] has a med list from most recent discharge from ED (emergency department). We did go through the medication list together. It appears nystatin is used in the groin area... Facility informed health direct that the cefdinir and doxy (doxycycline) were replaced with Augmentin. PLAN 1. [S/he] will get these medications out to the facility."

Resident 1's MAR indicated the Augmentin antibiotic was not started until 06/16/2024. This was 9 days after Resident 1's ER visit on 06/07/2024, when s/he was diagnosed with pyelonephritis and cellulitis.

On 06/12/2024, DON B documented the following assessment:
"Wound Assessment
Wound Type/Stage: Unstageable
Location: Coccyx
Description: Open area to coccyx.
Size 1 cm x 1.5 cm
Depth: unable to measure - no undermining or tunneling noted
Drainage: none
Signs of infection: none

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Wound Edges: smooth
Wound Base: 100% slough
Surrounding tissue: reddened and blanchable
Pain: no pain with dressing change
Wound healing: stable
Treatment: Mepilex dressing twice per day, encourage repositioning, wheelchair cushion.
Wound Assessment
Wound Type/Stage: Stage 2
Location: mid natal cleft (right buttock)
Size: 0.9 cm x 0.9 cm
Depth: 0.1 cm
Drainage: none
Signs of infection: none
Wound Edges: smooth
Wound Base: 75% granulation 25 % slough
Surrounding tissue: red and blanchable
Pain: No pain with dressing change
Wound healing: stable
Treatment: Mepilex dressing twice per day, encourage repositioning, wheelchair cushion.
Wound Assessment
Wound Type/Stage: Blister
Location: Left heel
Description: Intact blister that is partially fluid filled
Size: 3 cm x 1.5 cm
Depth: none
Drainage: none
Signs of infection: none
Wound Edges n/a (non-applicable)
Wound base: n/a
Surrounding tissue: blister and skin under the blister is of normal skin tone
Pain: none
Wound healing: stable
Treatment: heel protectors, elevate feet off bed. MD notified. Will suggest Home Health referral for wound care and catheter care. RN (registered nurse) suggests to MD to use calcium alginate covered with mepilex [sic] to be changed M, W, F

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(Monday, Wednesday, Friday) and as needed to both open areas on bottom. Continue to leave heal [sic] area open to air."

This note was faxed to Resident 1's physician on 06/12/2024. On 06/17/2024, Resident 1's physician returned the fax with the following order: "Will place referrals for wound and catheter care. Continue with bandage changes, surveillance of wounds."

This was the first assessment DON B documented for Resident 1's heel, after staff documented observing the blister on 06/07/2024. This is also the first note from DON B on Resident 1's coccyx wound since s/he noted on 05/31/2024.

On 06/18/2024, DON B documented the following wound care note:
"Wound Assessment
Wound Type/Stage: Unstageable
Location: Coccyx
Description: Open area to coccyx.
Size 1.8 cm x 1.4 cm
Depth: 0.6 cm
Drainage: none
Signs of infection: none
Wound Edges: smooth
Wound Base: yellow. Less slough noted.
Surrounding tissue: reddened and blanchable, some excoriation to around wound
Pain: no pain with dressing change
Wound healing: stable
Treatment: Mepilex dressing barrier cream, encourage repositioning, wheelchair cushion.
Wound Assessment
Wound Type/Stage: Stage 2
Location: mid natal cleft (right buttock)
Size: 0.2 cm x 0.2 cm

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N 431	Continued From page 58 Depth: <0.1 cm Drainage: none Signs of infection: none Wound Edges: smooth Wound Base: 100% granulation Surrounding tissue: red and blanchable Pain: No pain with dressing change Wound healing: improving Treatment: Mepilex dressing, barrier cream, encourage repositioning, wheelchair cushion. Wound Assessment Wound Type/Stage: Blister Location: Left heel Description: Intact blister that is dry. No fluid noted in blister. Area is dry. Size: 2.5 cm x 1.5 cm Depth: none Drainage: none Signs of infection: none Wound Edges n/a Wound base: n/a Surrounding tissue: blister and skin under the blister is of normal skin tone Pain: none Wound healing: stable Treatment: heel protectors, elevate feet off bed. Home Health Care will be here Friday to admit resident." Resident 1's coccyx pressure injury increased in size since 06/12/2024 with excoriation around the wound. On 06/21/2024, Home Health Registered Nurse (HHRN) S documented Resident 1's wound to the coccyx was a stage III pressure injury, measuring 8 cm in length, 7 cm in width, and 0.4 cm in depth. The wound had scant drainage described as "Serosanguineous: Thin, Pale Red/Pink, Watery." HHRN documented the wound to	N 431		

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Resident 1's left heel was a suspected deep tissue pressure injury. It was a closed area measuring 2.9 cm in length, 1.5 cm in width and no depth.

Resident 1's coccyx injury increased in size from 06/18/2024 to 06/21/2024.

On 06/23/2024, HHRN L documented: "PRN (as needed) visit due to facility calling at 1030 (10:30 AM) to report that patient had a BM at 330 AM and disconnected [his/her] catheter from bag. They also reported approximately a 1 inch blister that was intact on the thigh and another blister that had opened up. They reported [s/he] spilled coffee in [his/her] legs yesterday and did not report what time. On arrival patient was sitting at table grimacing [sic] POA (power of attorney) was present with [family]. Patient was assisted into the bed with maximum 2 assist. Patient was moaning in pain. Once patient was placed in bed writer was able to see the blisters. Multiple intact blister [sic] present in bilateral groin with opens [sic] areas of ruptured blisters. Are [sic] was 12 cm x 4 cm bilateral. Due to pain writer stopped assessment. Due to the complexity of the burn area and pain it was recommended that patient seek ED evaluation. Catheter appeared to be leaking, writer offered to change the catheter however POA and patient wanted to wait for ED as patient was in too much pain. EMS services requested ... On assessment writer note [sic] redness on the outer left knee that did not blanch and a pressure injury on the right ankle from button from catheter bag..."

On 07/22/2024 at approximately 10:30 AM., Surveyor interviewed Administrator A, DON B, Senior Vice President (VP) C, Vice President of Clinical Services D and Regional Nurse E.

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Surveyor asked when DON B was first notified about Resident 1's buttock wound as it was first noted by a caregiver on 05/19/2024 and DON B did not document until 05/31/2024. DON B said s/he wasn't notified of the wound until a week later after it was opened up. DON B said, "I believe they notified [HM F]." DON B confirmed HM F was not a nurse. DON B said the house managers were not notifying him/her as they should have. Surveyor asked when Resident 1's physician was notified of the pressure injury. DON B said the physician was notified on 05/31/2024. Surveyor requested documentation of this notification and any orders the physician would have ordered. Surveyor reviewed documentation from the provider and documentation from Resident 1's physician's office. The first fax sent to Resident 1's physician related to Resident 1's pressure injury to his/her buttocks was on 06/03/2024. This was approximately 2 weeks after 05/19/2024, when staff first documented the breakdown. Surveyor asked what interventions were updated to Resident 1's ISP related to his/her pressure injuries. DON B said they did add to Resident 1's care plan to reposition every 2 hours. DON B confirmed the ISP should have been updated to reflect Resident 1 had pressure injuries and confirmed it was not updated. Surveyor asked who completed Resident 1's assessment, dated 05/31/2024. DON B said HM F completed the assessment and s/he reviewed it. Surveyor asked if HM F or DON B physically assessed Resident 1 in person. DON B told Surveyor, "I know the residents." Surveyor reviewed Resident 1's skin condition was marked as good, even though DON B documented a wound note on the same date as the assessment, 05/31/2024. DON B confirmed the assessment was not accurate and said s/he must have missed that part. Surveyor asked DON B

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when s/he first assessed Resident 1's left heel. DON B said s/he assessed Resident 1's heel the same day as it was noted, 06/07/2024. Surveyor requested documentation for that assessment as Surveyor could not locate it. DON B told Surveyor, "I must have missed charting on it." Surveyor asked when Resident 1's physician was notified of the pressure injury to Resident 1's heel. DON B told Surveyor, "Not until the 12th." This would have been 06/12/2024, approximately 1 week after staff documented the blister.

The provider did not monitor the physical health of Resident 1's skin. They did not accurately assess Resident 1's skin when they completed their comprehensive assessment. Resident 1's ISP was not updated when Resident 1 developed a pressure injury to his/her coccyx and then his/her heel. Resident 1's physician was not immediately notified when Resident 1 had a change in condition with his/her skin. Resident 1 did not receive antibiotics timely after his/her ER visit on 06/07/2024, when s/he was diagnosed with having a stage III infected pressure injury. The pressure injury to Resident 1's coccyx increased in size. On 06/23/2024, the home health nurse assessed Resident 1 and discovered 2 additional pressure injuries. Resident 1 had redness on the outer left knee that did not blanch, and a pressure injury on Resident 1's right ankle caused from a button on the catheter bag. Resident 1 did not return to the facility after being sent to the hospital on 06/23/2024.

RESIDENT 2
On 7/10/2024, Surveyor reviewed Resident 2's record.

Resident 2 was admitted to the facility on

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03/21/2024. Resident 2 had diagnoses that included acute combined systolic (congestive) and diastolic (congestive) heart failure, type 2 diabetes with diabetic peripheral angiopathy without gangrene, type 2 diabetes with severe nonproliferative diabetic retinopathy without macular edema, paroxysmal atrial fibrillation, peripheral vascular disease, pulmonary hypertension, heart disease, acquired absence of right leg below knee, transient ischemic attack, heart disease, mitral value insufficiency.

An observation note, dated 04/08/2024, read, "Writer noticed legs were swollen. Writer asked [Resident 2] if they have been swollen like that for long. [S/he] said no, they normally aren't like that."

Resident 2's vital sign records from 06/01/2024 through 06/16/2024 documented 22 oxygen saturation readings under 90%, with the lowest reading being 74% on 06/09/2024. Oxygen readings were accompanied by staff comments that included "wheezy breathing," "wheezy," "SOB," (short of breath) "states [s/he] is having breathing issues."

On 07/18/2024, Surveyor reviewed Resident 2's 06/16/2024 ED report, which read, "Patient is a 75-year-old [fe/male] who is presenting to the [ED] from assisted living facility with concern for progressively worsening lower extremity edema and shortness of breath. On exam [s/he] was [sis] significant edema to above the level of [his/her] knees bilaterally. Lungs diffusely with rales concerning for edema.

Differential diagnosis includes, but not limited to pulmonary edema, CHF (chronic heart failure), renal issues, electrolyte/metabolic disturbances,

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infectious etiology such as pneumonia, among others."

According to hospital records, Resident 2 had been experiencing dyspnea and lower extremity edema for 3 to 4 weeks prior to 06/16/2024 when s/he presented to the ED and was subsequently hospitalized. Resident 2 was discharged to a skilled nursing facility on 07/01/2024. Resident 2's weight upon hospital admission was 249.12 lbs. and his/her discharge weight was 204.15 lbs.

According to Mayo Clinic, "Heart failure occurs when the heart muscle doesn't pump blood as well as it should. When this happens, blood often backs up and fluid can build up in the lungs, causing shortness of breath ... But heart failure can be life-threatening. People with heart failure may have severe symptoms. Some may need a heart transplant or a device to help the heart pump blood. Heart failure is sometimes called congestive heart failure ... If you have heart failure, your heart can't supply enough blood to meet your body's needs.

Symptoms may develop slowly. Sometimes, heart failure symptoms start suddenly. Heart failure symptoms may include:
- Shortness of breath with activity or when lying down.
- Fatigue and weakness.
- Swelling in the legs, ankles and feet.
- Rapid or irregular heartbeat.
- Reduced ability to exercise.
- Wheezing.
- A cough that doesn't go away or a cough that brings up white or pink mucus with spots of blood.
- Swelling of the belly area.
- Very rapid weight gain from fluid buildup.
- Nausea and lack of appetite.

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- Difficulty concentrating or decreased alertness.
- Chest pain if heart failure is caused by a heart attack ...

Call your health care provider right away if you have heart failure and:
- Your symptoms suddenly become worse.
- You develop a new symptom.
- You gain 5 pounds (2.3 kilograms) or more within a few days.

Such changes could mean that existing heart failure is getting worse or that treatment isn't working." (Retrieved from https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms-causes/syc-20373142 on 08/06/2024).

Surveyor reviewed a Misconduct Incident Report (MIR) submitted to the Department by Administrator A on 06/25/2024. The report, dated 06/17/2024, read, in part: "[Resident 2] was hospitalized at Mayo Hospital in Menomonie WI for fluid overload and heart failure, placed in the ICU and required to be diuresed of 25lbs [sic] of excess fluid. [S/he] is not in stage 4 kidney failure. [S/he] was diagnosed with a stage 3 wound to [his/her] coccyx."

On 07/18/2024 at approximately 12:20 PM, Surveyors interviewed DON B. Surveyor asked DON B about Resident 2's skin concerns, including the edema noted by staff in April and the coccyx wound identified in the MIR. DON B stated, "I was unaware [s/he] had a wound ... I don't believe [HM U] told me [Resident 2] had swollen legs."

Surveyor asked DON B about Resident 2's low oxygen saturations. DON B stated staff were

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expected to notify the nurse if a resident had a low oxygen reading. DON B stated s/he was not notified of Resident 2's low oxygen saturations that occurred between 06/01/2024 to 06/16/2024. DON B stated HM U told staff to quit reporting Resident 2's low oxygen readings. Surveyor asked if the medical provider was ever notified regarding low oxygen. DON B stated, "I don't believe so."

On 07/10/2024 at 12:40 PM, Surveyors interviewed DON B. DON B stated house managers were responsible for monitoring charting and reporting any concerns to DON B. DON B stated HM U was not a nurse. Surveyors asked if HM U was trained on how to monitor vitals and how to respond to vitals that were outside parameters. DON B stated s/he did not know. DON B was the clinical supervisor and facility administrator until May 2024.

During the survey, Surveyors reviewed 3 employee training records (Caregiver I, Lead Caregiver J, and Caregiver K). Based on this review, the provider did not have a system to ensure employees received minimum training, including training on recognizing and responding to resident changes in condition and the provider's policies and procedures prior to working with residents.

Resident 2 had complaints of feeling short of breath, wheezing, difficulty breathing, and lower extremity edema. His/her oxygen saturation fell below 90%, getting as low as 74%. This indicated Resident 2's CHF was worsening, causing fluid to back up into his/her lungs. The provider did not notify Resident 2's physician of these changes to his/her oxygen and breathing or make arrangements for him/her to be seen for

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worsening CHF. Resident 2 was subsequently hospitalized for fluid overload and heart failure. Resident 2 was hospitalized from 06/16/2024 through 07/01/2024 and discharged to a skilled nursing facility.

RESIDENT 3
On 07/10/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on 10/10/2023 and discharged to the hospital on 04/20/2024.

According to his/her ISPs, Resident 3's primary diagnoses was anxiety. Resident 3's diagnostic list also included diabetes, chronic kidney disease, a history of vitamin deficiencies, irritable bowel syndrome with chronic diarrhea, and major depressive disorder.

Resident 3's daily charting indicated s/he experienced a change in condition in April 2024. Resident 3's progress notes included:

04/11/2024 - "Resident is having increased anxiety today and isolating [him/herself] to [his/her] room. Vitals have been taken and nurse has been notified. Fax was sent to doctor."

04/12/2024 at 10:25 AM - "Staff went to go and check on [Resident 3] and [his/her] anxiety has seem [sic] to be the same as yesterday or worse. [S/he] is still isolating [him/herself] in [his/her] room. [S/he] also has refused to eat anything. Staff has been going in and out of [his/her] room all morning to reassure [him/her] that [s/he] is not alone, as [s/he] keeps telling staff that [s/he] feels so alone here."

04/12/2024 at 4:28 PM - "Writer had sent out a fax to resident's MD to update [his/her] anxiety

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meds as [s/he] has been having a difficult time since yesterday morning. Doctor fax cam [sic] back and [s/he] wants to see [Resident 3] in the office to review med changes. Appointment will be set up next week for resident to see doctor. Until then, staff is to keep reassuring [him/her] that [s/he] is fine and that [s/he] can ring for help when needed and to make sure schedule [sic] meds are being given at appropriate times."

04/15/2024 - "Staff came and got writer and stated that resident was shaking and breathing heavy. Writer went and seen [sic] resident and writer had seen resident like this once before and knew that [his/her] anxiety was high again and so writer sat with resident and talked with [him/her] to find out what was wrong. Resident stated that [s/he] was scared that [s/he] was going to fall if [s/he] got up to go [sic] the bathroom, so writer told [him/her] to ring for help whenever [s/he] had to go and that we would help [him/her] and resident stated then that [s/he] was scared that if [s/he] went to the bathroom that the pad on [his/her] butt would fall off so writer assured [him/her] that we had more and that we could fix it. Also, remined [Resident 3] that [s/he] had a MD appointment on Thursday to go over [his/her] meds. Writer told RN about what was happening with resident. Family was updated via email."

04/17/2024 - "Staff had came [sic] and got writer again and was told that resident had not come out of [his/her] room yet and that [s/he] has not been eating very much. Writer went and seen [sic] resident and resident was upset and scared again over falling and if [s/he] ate or drank that [s/he] would have to go to the bathroom, writer reminded [him/her] what we had talked about 2 days prior [sic] resident stated that [s/he] remembered but is afraid that nobody will come

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because they will be busy. Resident repeated what [s/he] had said to writer days prior, so writer wrote up a little sign that stated that [s/he] could ring for help and we will come and help [him/her] [sic] that if the patch falls off we can replace it, that if [s/he] didn't eat or drink that our bodies get undernourished and we become dehydrated and weak. And that if all we do is sit in the chair that our butt gets sore and could cause our skin to break down, so we need to eat to stay healthy and feel better. Resident liked the sign that writer made and resident did order French toast of [sic] the alternative menu to eat and had a protein shake as well. Writer reported this to the nurse."

04/20/2024 - "Staff contacted Writer to let me know that resident was admitted to the hospital after [his/her] [family member] took [Resident 3] to the ER today. Staff stated that they did not know why [s/he] was admitted to the hospital and writer knows that [s/he] was just to the MD on Thursday for a med review and to address [his/her] high anxiety that [s/he] seem [sic] to be having lately."

The provider obtained Resident 3's weight 4 times during his/her placement. Weights obtained between December 2023 and March 2024 suggested Resident 3's weight did not fluctuate at baseline as all weights were within 1 pound of the previous month. Resident 3's weight on 03/01/2024 was 163 lbs., and on 04/01/2024, it was 184.8 lbs.

Resident 3's March 2024 intake charting suggested s/he consistently ate over 75% of his/her meals at baseline (s/he ate 86 of 93 meals in March 2023). Staff recorded a significant deviation from Resident 3's baseline intake in April. Between 04/10/2024 and 04/20/2024,

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Resident 3 declined 22 of 32 recorded meals (staff did not complete Resident 3's meal charting on 04/08/2024 or 04/09/2024).

According to Resident 3's ISP, dated 12/20/2023, "Staff to monitor bowel movements. If no BM in 3 days, see bowel protocol." Resident 3's BM charting indicated s/he had 4 BMs in April: 04/02/2024 (large), 04/10/2024 (medium), 04/14/2024 (small), and 04/19/2024 (small). This was a decrease in BM frequency recorded in February and March, and there was no indication in Resident 3's records that a bowel protocol was initiated.

Resident 3's record did not include documentation that the provider communicated these changes to Resident 3's physician. Resident 3's record did not include information regarding the 04/18/2024 medication review appointment referenced in Resident 3's progress notes on 04/20/2024.

Resident 3's medication administration record indicated Resident 3 was prescribed 2 new medications on 04/18/2024 (the date of his/her medication review appointment) - Tylenol, give 1000mg by mouth 3 times daily and clotrimazole cream 1%, apply to abdominal fold twice daily.

Resident 3's shower and skin audit charting indicated s/he received 1 shower between 03/31/2024 and 04/20/2024. The shower and skin audit occurred on 04/14/2024. Staff documented the tasks as complete; the record did not indicate Resident 3 had any skin concerns.

On 07/18/2024, Surveyor reviewed Resident 3's ED report and hospital records, dated 04/20/2024 through 05/07/2024. Resident 3 was seen at the

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N 431	Continued From page 70 ED on 04/20/2024 and admitted to the hospital for urinary retention and probable urinary tract infection [UTI], failure to thrive, and gluteal pressure ulcers. Resident 3 transferred to a post-acute care unit on 04/25/2024 and discharged home on 05/07/2024. The hospital discharge summary, dated 04/25/24, read, "Patient initially presented on the 20th of May... for evaluation of weakness, buttock and back pain. [Son/Daughter] reported that patient had not gotten up from [his/her] chair for the last week due to back and buttock pain ... Patient also reported left-sided abdominal pain on prone presentation in the [ED]. In the ED [s/he] was very anxious. Due to [his/her] pain [s/he] was given a dose of Dilaudid and became somewhat sedated. Patient with history of dementia but POA [power of attorney] was not active prior to admission. Patient was found to have urinary retention and a Foley catheter was placed with drainage over 1000 mL of urine. Urinalysis showed pyuria and patient was started of Rocephin for presumed UTI. CT scan of the abdomen and pelvis did not show acute abnormality. Patient was found to have a decubitus buttock ulcer though this did not appear infected. Patient was admitted for treatment of UTI with urinary retention along with failure to thrive ... patient has noted improvement in [his/her] pain today and seems to be doing well with just the Tylenol and lidocaine patches. Urine culture was negative, and antibiotics were stopped after 3 days. In addition [his/her] Foley catheter was removed just prior to being discharged today. Patient reports that [s/he] was feeling anxious but otherwise denies significant pain at this moment. [S/he] denies lightheadedness/dizziness, nausea/vomiting, shortness for breath, cough, chest pain, abdominal pain. Patient was initially constipated and then received laxative therapy and had	N 431		

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subsequent significant diarrhea. Patient now has not had a [BM] in a few days. Patient was transferring to the TCU [trauma care unit] today for further medical management and rehabilitation therapies."

On 07/18/2024 at 10:30 AM, Surveyors interviewed Administrator A, DON B, VP C, Vice President of Clinical Services D, and Regional Nurse E. Surveyor asked if the provider assessed Resident 3 in April 2024. VP C stated Resident 3 was assessed by physical therapy on 04/16/2024. VP C stated the provider did not have a copy of the assessment, but if therapy had any concerns, they would have reported it to DON B. DON B could not recall if there were any concerns noted during the assessment. Surveyor asked if the concerns were documented anywhere and DON B replied, "Probably not."

Surveyor asked if Resident 3's 21.8 lbs. weight increase between March and April 2024 was reported to Resident 3's physician. DON B stated, "Probably not."

Surveyor asked about Resident 3's skin condition. DON B reviewed Resident 3's record and stated Resident 3 did not have any documented skin breakdown since January 2024. Surveyor asked why Resident 3 was prescribed clotrimazole cream 1% on 04/18/2024. DON B stated s/he was unsure but s/he would send Surveyor the after-visit summary (AVS) report from Resident 3's 04/18/2024 physician appointment. VP C stated staff were expected to do a full body audit during scheduled skin audits, including lifting folds and looking between toes, etc. VP C stated that if they notice anything out of the ordinary, staff were expected to document the concern in charting. DON B confirmed Resident 3's last skin

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audit was completed on 04/14/2024 and it was unremarkable.

Surveyor asked about the physician notice and appointment referenced in Resident 3's notes above (i.e. fax sent to his/her physician on 04/12/2024 and the "MD appointment" on 04/18/2024). DON B and VP C reviewed Resident 3's record and did not find documentation related to these dates. VP C stated they would contact Resident 3's physician and obtain a copy of the records.

Surveyor asked about Resident 3's BM protocol. VP C stated the provider obtained standing orders for typical BM issues, but the orders were not activated until necessary. VP C stated that if a resident had irregular BMs or concerns, then the provider was expected to notify the physician and ask for the standing BM protocol orders to be activated. VP C stated Resident 3's BM protocol was not activated during his/her placement.

Surveyor asked DON B if s/he reviewed Resident 3's meal intake charting in April. DON B stated, "We don't do..." then asked Surveyor for clarification on the referenced documentation. Surveyor referenced Resident 3's April 2024 Recorded Care Report provided by DON B to Surveyor on 07/10/2024. DON B reviewed the documentation and stated Resident 3 should have been assessed.

Surveyor reviewed Resident 3's progress notes from 04/11/2024 to 04/17/2024, which referenced Resident 3's increased anxiety, isolation, change in diet, and fear of falling, and asked if these observed changes should have resulted in an assessment. DON B stated the observations "wouldn't necessarily trigger an assessment ... I

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talked to [Resident 3] quite a few times, but I guess I didn't document it." VP C stated, "[Resident 3] should have had a full assessment ... [His/her] care plan should have reflected a behavior plan for anxiety, skin breakdown ... there wasn't the right clinical follow up."

Surveyor asked what concerns were shared with Resident 3's physician in April 2024. VP C stated s/he would send the fax notifications to Surveyor for review.

On 07/18/2024, Surveyor received the AVS report from Resident 3's 04/18/2024 appointment, from VP C. The AVS read, in part: "[Resident 3] is complaining of significant pain in the buttock and has redeveloped but [sic] sores ... [S/he] has not eating [sic] or drinking well at all because of the pain and not wanting to go to the bathroom. It is most painful when [s/he] shifts position on [his/her] buttocks ... [s/he] has shear pressure sores on both medial buttocks in a symmetrical pattern ... Under [his/her] skin folds [s/he] has tinea corporis but no skin breakdown ... Pressure Injury (Ulcer) Of Right Buttock Stage 2 ... The big issue here is pressure. [S/he] does not need even the Mepilex boarder. They need to stop using the thick pad. If [s/he] does not care for the Desitin on [his/her] clothing, [s/he] should just use depends [sic]. I did refer to home health care and OT (occupational therapy) and PT (physical therapy) for assistance with mainly positioning and increasing activity. I think the skin issue will actually heal up very quickly." Resident 3's physician ordered acetaminophen 1000 mg 3 times a day for buttock pain and clotrimazole 1%, apply 2 times per day to clean and dry skin underneath abdominal folds until rash clears.

On 07/19/2024, Surveyor received a copy of the

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N 431	Continued From page 74 fax notification sent to Resident 3's physician on 04/12/2024 from VP C. The fax read, "Resident seems to be having increase [sic] anxiety, shaking, unsure what to do but not really able to tell us what the matter is. [His/her] vitals have been checked; all are within normal range. Resident is isolating [him/herself] in [his/her] room and skipping meals. I have included [his/her] med list for you to look over and see what changes, if any, can be made... [HM F]." Resident 3's physician responded, "Patient should be seen to assess med changes." The provider did not monitor and arrange for medical intervention when Resident 3 experienced a change in condition in April. Staff care charting indicated Resident 3 experienced a change in bowel patterns, eating, and social activity between 04/12/2024 and 04/17/2024. The provider concluded Resident 3's changes were related to anxiety however, they did not assess Resident 3 or implement interventions to assist with Resident 3's mental health condition. On 04/18/2024, Resident 3 had a medication review appointment with his/her physician that resulted in new prescriptions for pain and skin concerns; however, the provider did obtain documentation from this appointment, so they were unaware of the concerns identified during the appointment (pain, skin rash, pressure ulcer). The provider did not assess Resident 3 or implement interventions to assist with Resident 3's change in condition. Resident 3 was hospitalized emergently on 04/20/2024 and s/he did not return to the facility. RESIDENT 5 On 07/10/2024 at approximately 10:00 AM, Surveyor requested Resident 5's record, including all ISPs and vital sign records for Resident 5	N 431		

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since admission, from Administrator A and DON B.

On 07/10/2024, Surveyor reviewed Resident 5's records. Resident 5 was admitted on 03/20/2024 with diagnoses that included acute combined systolic (congestive) and diastolic (congestive) heart failure, type 2 diabetes with diabetic peripheral angiopathy without gangrene, paroxysmal atrial fibrillation.

Observation notes stated Resident 5's physician was notified of changes to wounds on 4/22/2024. Resident 5's record did not include evidence of this notification or a physician response to the change in condition.

Resident 1's record included 1 ISP, dated and signed 05/06/2024. The ISP read, in part: "Cardiac Management: Obtain weekly weight. Report gain of > (over) 3lbs [sic] in one week."

Surveyor reviewed Resident 5's vital sign records. The following three weights were documented: 3/22/2024 (250.2lb), 4/1/2024 (248.8lbs), and 5/3/2024 (252lbs).

On 7/10/2024 at approximately 9:15 AM, Surveyor interviewed Caregiver H. Surveyor asked Caregiver H if anyone was on frequent vital sign monitoring. Caregiver H reported that Resident 5 was on weekly weights.

On 07/22/2024 at approximately 10:30 AM, Surveyor interviewed DON B and Administrator A. Administrator A stated that the weights were being taken and handed over to a house manager who never documented them. Surveyor asked DON B if there was any documentation regarding Resident 5's weekly weights. DON B

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A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

(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 431	Continued From page 76 stated s/he was unsure. Surveyor asked whose responsibly it was to monitor vital signs. Administrator A stated staff were expected to enter it on the computer and write it on paper to give to DON B. Surveyor asked about Resident 5's wound and documentation related to the notification that was made to his/her physician on 04/22/2024. The provider indicated they would review Resident 5's record and send documentation by the end of the day. On 07/22/2024 at 3:42 PM, Surveyor received an email from VP C that read, "Attached are the records we were able to locate." The email attachment did not include additional documentation related to the physician notification on 04/22/2024. The provider did not monitor Resident 5's weight weekly or retain documentation of all communication with Resident 5's physicians. Cross references: N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0230 DHS 83.19 Orientation N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 431		