STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019987	A. BUILDING: _____ B. WING _____	C 12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1ST HEALTH LLC	215 3RD ST MONROE, WI 53566

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments From 12/18/2024 to 12/27/2024, the bureau of assisted living southern regional office conducted a complaint investigation at 1st Health LLC a CBRF located in Monroe, WI. As a result of this survey, 16 violations of DHS Chapter 83 were issued. Complaint was substantiated. Census: 6	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the	N 158		

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

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provider did not report misappropriation of resident property to the department on the form provided by the department, within 7 calendar days from the date the provider knew about the misappropriation of property.

From 10/25/2024 to 12/17/2024, Provider did not report to the department after obtaining substantial evidence Caregiver D had misappropriated approximately $250.00 in total from resident(s).

FINDINGS INCLUDE:

On 11/27/2024, the department received a complaint which alleged misappropriation.

On 12/18/2024, Surveyor reviewed department records and did not find a self-report or caregiver misconduct report on file.

On 12/18/2024, Surveyor arrived at facility for a complaint investigation.

On 12/18/2024 at 9:30 AM, Surveyor interviewed Administrator A. Administrator A stated s/he had started his/her position on 11/18/2024. Administrator A stated s/he had been told a previous employee had stolen gift cards from Resident 1 and Resident 2. Stated s/he had not been told any more information regarding the theft.

On 12/18/2024 at 10:08 AM, Surveyor interviewed Resident 1. Resident 1 stated s/he had treated Caregiver D like a daughter. Resident 1 stated s/he had left his/her purse alone with Caregiver D on a few occasions. Resident 1 stated s/he had approximately $200.00 in cash stolen from his/her purse. Resident 1 stated s/he

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did not realize money had gone missing from his/her purse until a $50.00 gift card s/he had been saving for Christmas shopping went missing. Stated Caregiver D helped him/her look for the missing money. Resident 1 stated another staff member produced the missing $50.00 gift card and stated Caregiver D had given him/her the gift card to pay back a debt between them. Resident 1 stated Licensee B ended up reimbursing him/her for the missing money. Resident 1 stated s/he was embarrassed due to this incident.

On 12/18/2024, Surveyor reviewed Resident 1's facility face sheet. Resident 1 was admitted to the facility on 09/24/2021. Resident 1 had an activated financial power of attorney (Family Member K) and managed care organization (MCO) case manager (Social Worker I).

On 12/18/2024 at 4:05 PM, Surveyor discussed the above concern with Administrator A, Licensee B and Manager C. Administrator A, Licensee B, and Manager C, acknowledged cash and gift cards had been misappropriated from Resident 1 and Resident 2. Licensee B acknowledged Caregiver D had not been reported to the office of caregiver quality (OCQ) nor a self-report document sent to bureau of assisted living (BAL). Licensee B stated s/he was not aware of the reporting requirement regarding community based residential facilities (CBRF).

On 12/20/2024, Surveyor reviewed police report #M2406466. On 11/01/2024 at 2:05 PM, Officer H documented the following, "This RO spoke with the co-owner, [Licensee B], of [Name of Previous Management Company] by phone. [Licensee B] stated that [s/he] had completed an internal investigation of [Caregiver D] [DOB]. [Licensee

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N 158	Continued From page 3 B's] investigation showed that [Caregiver D] had taken money from two residences, [Resident 2] and [Resident 1] stated that they suspected [Caregiver D] because [s/he] used a gift card with the same number as one of the victims. [Licensee B] stated that the victim's, [Resident 2] and [Resident 1], did not want [Caregiver D] charged with a crime. [Licensee B] stated the [Name of Previous Management Company] would replace the stolen money and terminate [Caregiver D]. [Licensee B] wanted an information case at the [Name of Local Police Department] to document the incident. Case Closed ..." CROSS REFERENCE N0170 83.12(5)(b) Notification: Abuse And Neglect Allegations CROSS REFERENCE N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws CROSS REFERENCE N0219 83.17(1) Licensee Conduct Caregiver Background Check CROSS REFERENCE N0348 83.32(3)(d) Rights of Residents: Freedom From Mistreatment	N 158		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the department within 3 working days after an incident or accident which resulted in serious	N 165		

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injury requiring hospital admission or emergency room treatment of a resident.

On 10/29/2024, Family Member J transported Resident 3 to an emergency room (ER). Family Member J reported facility staff had witnessed Resident 3 fall on Saturday (10/26/2024) and Sunday (10/27/2024). While in the ER Resident 3 was diagnosed with 3 different fracture on 2 ribs. Resident 3 was admitted to the hospital for the next 7 days. Family Member J discharged Resident 3 from facility on 11/09/2024 due to concern for Resident 3's safety.

FINDINGS INCLUDE:

Facility was granted a probationary license on 07/18/2024. The facility was licensed as 12-bed, non-ambulatory, community based residential facility (CBRF). Facility provided care to the following client groups: terminally ill, developmentally disabled, traumatic brain injury (TBI), physically disabled, advanced aged, irreversible dementia & Alzheimer's.

On 11/27/2024, the department received a complaint which alleged abuse.

On 12/18/2024, Surveyor reviewed department records and did not find a self-report or caregiver misconduct report on file.

On 12/18/2024, Surveyor arrived at facility for a complaint investigation.

On 12/28/2024 at 10:00 AM, Surveyor reviewed Resident 3's facility record. Resident 3's facility record was partially on the electronic health record (EHR) and in a large filing cabinet in Administrator A's office. Administrator A handed

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all paper records on file for Resident 3 to Surveyor. Surveyor reviewed Resident 3's paper record. Surveyor found Resident 3's admission agreement from previous management company, incident report, and an individualized service plan (ISP). Administrator A stated s/he printed all of Resident 3's EHR records then handed Surveyor Resident 3's facility face sheet. Administrator A stated facility was not affiliated with an RN. Administrator A stated facility did not have assessments or staff notes describing Resident 3's fall and hospital admission in October 2024. Administrator A denied documentation of allegations of abuse related to Resident 3's hospital admission.

On 12/18/2024, Surveyor reviewed Resident 3's face sheet. Resident 3 was admitted to the facility on 03/31/2024. Resident 3 was discharged from the facility on 11/09/2024. Social Worker N was listed as Resident 3's managed care organization (MCO) case manager. Nurse O was listed as Resident 3's MCO RN (registered nurse) case manager.

On 12/18/2024, Surveyor reviewed Resident 3's individualized service plan (ISP) dated 05/24/2024. Resident 3's ISP documented s/he had an activated power of attorney (APOA). Family Member J signed Resident 3's ISP and wrote, "POA," next to his/her signature. Resident 3 was documented as, "24-hour supervision." Resident 3 utilized a walker for ambulation.

On 12/18/2024, Surveyor reviewed a facility incident report. Previous Administrator F documented the following, "INCIDENT TITLE: [Resident 3] was getting out of bed and lost [his/her] balance and slipped and fell ...CAREGIVER ON SHIFT: [Caregiver D] ...DATE

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OF INCIDENT: 10/30/2024 ...RESIDENT NAME: [Resident 3] ...INCIDENT DESCRIPTION: [Resident 3] was getting out of bed on [his/her] own and while trying to get off [s/he] lost [his/her] balance and fell ...We checked [him/her] and did not notice any physical injury ...We called and notified [his/her] family who came in and evaluated the situation and decided to take [Resident 3] to the hospital to be evaluated."

On 12/28/2024 at 4:05 PM, Surveyor discussed the above concern with Administrator A, Licensee B, and Manager C. Licensee B and Manager C acknowledged Resident 3 fell into a wall and was sent to an ER for treatment. Licensee B and Manager C acknowledged Resident 3 was diagnosed with approximately 3 rib fractures and admitted to the hospital. Licensee B and Manager C acknowledged a self-report was not sent to the department.

On 12/19/2024 at 1:45 PM, Surveyor discussed the above concern with Social Worker N. Social Worker N reported s/he had not been notified of Resident 3's rib fractures until s/he was called by the hospital.

On 12/19/2024 at 2:46 PM, Nurse O emailed Surveyor Resident 3's emergency room record dated 10/29/2024. The emergency room record documented the following, " CHIEF COMPLAINT: falls at [his/her] assisted living facility on 10/26 and 10/27...HISTORY OF PRESENT ILLNESS: Patient is a 97 year old [man/woman] with a history of dementia who currently resides at an assisted living facility. [Family Member J] is very involved in [his/her] care ... [Family Member J] gives most of the history as patient is a poor historian. [S/he] states that caregivers at [his/her] assisted living facility found [him/her] after falling

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onto [his/her] right side on 10/26. [S/he] had no obvious injuries at that time. [S/he] was again found on 10/27 after having a fall. Furniture was shifted and [Family Member J] presumes that [s/he] likely fell causing this to happen. Since then [s/he] has had pain in the left chest area and increasing confusion from [his/her] baseline. [S/he] is also had weakness, decreased appetite and worsened mobility from [his/her] baseline. [S/he] denies any nausea, vomiting, fevers, or urinary complaints. Workup in the emergency room was remarkable for fractures on the anterior left #3 and 4, ribs with rib #3 fractured in more than 1 place ...Because of [his/her] unsteady gait, multiple rib fractures, and weakness, it was felt that [s/he] was unsafe to return to [his/her] apartment at home ... ASSESSMENT/PLAN ...1. Multiple falls at independent living facility; multiple anterior left rib fractures #3 and #4: [His/Her] falls are likely due to orthostatic hypotension. We are holding Lasix and decreasing Norvasc. Will treat pain with Tylenol, lidocaine patches, and diclofenac gel ...Return to assisted living facility tomorrow as long as she is doing well. [Family Member J] involved and in agreement ...2. Altered mental status, worsening confusion with underlying dementia: Per [Family Member J] [s/he] has had worsening confusion over the last days. [S/he] seems to be improving since admission. Is likely multifactorial related to recent fall possible sleep deprivation and pain. Continue supportive care ...".

On 12/19/2024 at 3:30 PM, Surveyor called Licensee B. Surveyor asked why the facility incident report was dated for a time Resident 3 was physically at the hospital. Licensee B stated Previous Administrator F must have documented the incorrect date on the incident report. Licensee B stated s/he had not been made aware of

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N 165	Continued From page 8 Resident 3 falling on 10/26/2024 and 10/27/2024. Licensee B stated staff were expected to report and document all falls and injuries. Licensee B reported Family Member J had reported satisfaction with facilities care of Resident 3. CROSS REFERENCE N0170 DHS Chapter 83.12(5)(b) Notification: Abuse And Neglect Allegations CROSS REFERENCE N0196 DHS Chapter 83.14(2)(a) Licensee Ensure Facility Complies With Laws CROSS REFERENCE N0353 DHS Chapter 83.32(3)(i) Rights Of Residents: Adequate Treatment CROSS REFERENCE N0381 DHS Chapter 83.35(1)(a) Pre-Admission And Ongoing Assessments	N 165		
N 170	83.12(5)(b) Notification: abuse and neglect allegations. The CBRF shall immediately notify the resident ' s legal representative when there is an allegation of physical, sexual or mental abuse, or neglect of a resident. The CBRF shall notify the resident ' s legal representative within 72 hours when there is an allegation of misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify the resident's legal representative within 72 hours when there was an allegation of misappropriation of property. On 10/25/2024, Previous Administrator F documented Caregiver D had stolen approximately $250.00 in total from Resident 1	N 170		

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N 170	Continued From page 9 and Resident 2. On 11/01/2024, Licensee B reported Caregiver D to the local police department for stealing a total in $250.00 worth of cash and gifts from Resident 1 and Resident 2. Licensee B reported to the police Resident 1 and Resident 2 did not want to press charges. On 12/20/2024, Surveyor contacted Resident 1's MCO case manager (Social Worker I) and activated financial power of attorney (Family Member K). Social Worker I nor Family Member K had been notified of the misappropriation of Resident 1's cash and gift card. FINDINGS INCLUDE: Facility was granted a probationary license on 07/18/2024. The facility was licensed as 12-bed, non-ambulatory, community based residential facility (CBRF). Facility provided care to the following client groups: terminally ill, developmentally disabled, traumatic brain injury (TBI), physically disabled, advanced aged, irreversible dementia & Alzheimer's. On 11/27/2024, the department received a complaint which alleged misappropriation. On 12/18/2024, Surveyor arrived at facility for a complaint investigation. On 12/18/2024 at 9:30 AM, Surveyor interviewed Administrator A. Administrator A stated s/he had started his/her position on 11/18/2024. Administrator A stated s/he had been told a previous employee had stolen gift cards from Resident 1 and Resident 2. Stated s/he had not been told any more information regarding the	N 170		

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theft.

On 12/18/2024 at 10:08 AM, Surveyor interviewed Resident 1. Resident 1 stated s/he had treated Caregiver D like a daughter. Resident 1 stated s/he had left his/her purse alone with Caregiver D on a few occasions. Resident 1 stated s/he had approximately $200.00 in cash stolen from his/her purse. Resident 1 stated s/he did not realize money had gone missing from his/her purse until a $50.00 gift card s/he had been saving for Christmas shopping went missing. Stated Caregiver D helped him/her look for the missing money. Resident 1 stated another staff produced the missing $50.00 gift card and stated Caregiver D had given him/her the gift card to pay back a debt between them. Resident 1 stated Licensee B ended up reimbursing him/her for the missing money. Resident 1 stated s/he was embarrassed due to this incident.

On 12/18/2024, Surveyor reviewed Resident 1's facility face sheet. Resident 1 was admitted to the facility on 09/24/2021. Resident 1 had an activated financial power of attorney (Family Member K) and managed care organization (MCO) case manager (Social Worker I).

On 12/18/2024 at 4:05 PM, Surveyor discussed the above concern with Administrator A, Licensee B and Manager C. Administrator A, Licensee B, and Manager C, acknowledged cash and gift cards had been misappropriated from Resident 1 and Resident 2.

On 12/20/2024, Surveyor reviewed police report #M2406466. On 11/01/2024 at 2:05 PM, Officer H documented the following, "This RO spoke with the co-owner, [Licensee B], of [Name of Previous Management Company] by phone. [Licensee B]

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stated that [s/he] had completed an internal investigation of [Caregiver D] [DOB]. [Licensee B's] investigation showed that [Caregiver D] had taken money from two residences, [Resident 2] and [Resident 1] stated that they suspected [Caregiver D] because [s/he] used a gift card with the same number as one of the victims. [Licensee B] stated that the victim's, [Resident 2] and [Resident 1], did not want [Caregiver D] charged with a crime. [Licensee B] stated the [Name of Previous Management Company] would replace the stolen money and terminate [Caregiver D]. [Licensee B] wanted an information case at the [Name of Local Police Department] to document the incident. Case Closed ..."

On 12/20/2024 at 11:30 AM, Surveyor called Social Worker I. Social Worker I stated s/he had been Resident 1's MCO case manager since 2023. Social Worker I stated Resident 1 had an activated financial power of attorney who was Family Member K. Social Worker I confirmed s/he had the documentation confirming Family Member K was Resident 1's activated financial power of attorney. Social Worker I denied being notified of Resident 1's cash and gift cards being misappropriated. Social Worker I stated it was an expectation the facility would notify Resident 1's MCO case manager of misappropriation of funds.

On 12/20/2024 at 3:47 PM, Family Member K called Surveyor. Family Member K stated s/he was Resident 1's activated financial power of attorney. Family Member K stated Social Worker I had just notified him/her that day of Resident 1's funds being misappropriated. Family Member K stated Resident 1 had been happier since the new owners took over this Summer. Family Member K stated s/he was surprised none of the staff called him/her to tell him/her about this.

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N 170	Continued From page 12 CROSS REFERENCE N0158 83.12(2)(a) Caregiver: Investigating Abuse & Neglect CROSS REFERENCE N0165 83.12(4)(c) Reporting Incidents With Serious Injury CROSS REFERENCE N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws CROSS REFERENCE N0219 83.17(1) Licensee Conduct Caregiver Background Check CROSS REFERENCE N0348 83.32(3)(d) Rights of Residents: Freedom From Mistreatment	N 170		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and interview, the licensee did not ensure the CBRF (community based residential housing) and its operation complied with all laws governing the CBRF. On 07/18/2024, the department issued provider a probationary CBRF license. From 12/18/2024 to 12/27/2024, Surveyor conducted a complaint investigation. During investigation the complaint was substantiated, and 17 violations of DHS Chapter 83 were identified. FINDINGS INCLUDE: Facility was granted a probationary license on	N 196		

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	0019987	A. BUILDING: _____ B. WING _____	C 12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1ST HEALTH LLC	215 3RD ST MONROE, WI 53566

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N 196	Continued From page 13 07/18/2024. The facility was licensed as 12-bed, non-ambulatory, community based residential facility (CBRF). Facility provided care to the following client groups: terminally ill, developmentally disabled, traumatic brain injury (TBI), physically disabled, advanced aged, irreversible dementia & Alzheimer's. On 11/27/2024, the department received a complaint which alleged concerns at facility. On 12/18/2024, Surveyor arrived at facility for a complaint investigation. On 12/18/2024 at approximately 8:30 AM, Surveyor reviewed the department face sheet with Administrator A. Administrator A reported s/he was the individual responsible for the day-to-day operation of the CBRF. Administrator A stated the department face sheet was inaccurate, with Licensee B listed as both the licensee and administrator. Administrator A stated Licensee B owed the facility but maintained his/her primary residence outside of the state of Wisconsin. Administrator A reported s/he had been hired to be the facility administrator on 11/18/2024. Administrator A stated s/he had been given zero training in how to be an administrator for a CBRF. Administrator A stated s/he would clarify who should be listed as the facility administrator on the department face sheet with licensee (Licensee B & Manager C) before the end of the day. From 12/18/2024 to 12/17/2024, Surveyor identified the following violations of DHS Chapter 83: 1.) 83.12(2)(a) Caregiver: Investigating Abuse & Neglect 2.) 83.12(4)(c)Reporting Incidents With Serious	N 196		

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N 196	Continued From page 14 Injury 3.) 83.12(5)(b) Notification: Abuse And Neglect Allegations 4.) 83.16(2) Resident Care Staff At least 18 years Old 5.) 83.17(1) Licensee Conduct Caregiver Background Check 6.) 83.17(2)(a) Employees Screened For Communicable Disease 7.) 83.29(2) Admission Agreement Include Services, Charges 8.) 83.32(3)(d) Rights Of Residents: Freedom From Mistreatment 9.) 83.32(3)(i) Rights Of Residents: Adequate Treatment 10.) 83.32(3)(n) Rights Of Residents: Safe Environment 11.) 83.35(1)(a) Pre-Admission And Ongoing Assessments 12.) 83.35(3)(a) Comprehensive Individualized Service Plan 13.) 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake 14.) 83.37(2)(d) Documentation Of Medication Administration 15.) 83.38(1)(c) Leisure Time Activities	N 196		
N 218	83.16(2) Resident care staff at least 18 years old Resident care staff shall be at least 18 years old. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure resident care staff were at least 18 years old. On 12/18/2024, Surveyor reviewed Caregiver F's staff record. Caregiver F was 17 years old. No,	N 218		

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N 218	Continued From page 15 waiver from department was documented. FINDINGS INCLUDE: Facility was granted a probationary license on 07/18/2024. The facility was licensed as 12-bed, non-ambulatory, community based residential facility (CBRF). Facility provided care to the following client groups: terminally ill, developmentally disabled, traumatic brain injury (TBI), physically disabled, advanced aged, irreversible dementia & Alzheimer's. On 11/27/2024, the department received a complaint which alleged facility employed people under the age of 18. On 11/27/2024, Surveyor reviewed department records. The department did not have documentation of a waiver granted to the facility for staff under the age of 18. On 12/18/2024, Surveyor arrived at facility for a complaint investigation. On 12/18/2024 at 8:35 AM, Surveyor interviewed Administrator A. Surveyor asked if all staff employed by facility were at least 18 years old. Administrator A stated Caregiver F was 17 years old. Administrator A stated s/he had texted Licensee B and Manager C when s/he realized it wasn't permitted for resident care staff to be under the age of 18. Administrator A stated Licensee B and Manager C did not provide a resolution for Administrator A. Administrator A stated Caregiver F was currently a night shift staff member. Administrator A stated Caregiver F was scheduled alone often overnight to supervise/provide personal cares to 5 residents. Administrator A stated Caregiver F had not been	N 218		

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N 218	Continued From page 16	N 218		

trained to administer medication but was expected to call staff from neighboring facility to administer requested a PRN (as needed) medication. Administrator A stated s/he had not applied for a waiver from the department for Caregiver F to work facility.

On 12/18/2024 at 10:10 AM, Surveyor interviewed Caregiver G. Caregiver G stated Caregiver F had been working night shifts for the last 2 months. Caregiver G stated Caregiver F reported to him/her that Manager C told Caregiver F to not-disclose his/her age to fellow staff.

On 12/18/2024, Surveyor reviewed Caregiver F's staff record. Caregiver F was hired on 11/12/2024. According to Caregiver F's driver's license s/he was 17 years old at the time of survey.

On 12/18/2024 at 4:05 PM, Surveyor discussed the above concern with Administrator A, Licensee B and Manager C. Manager C stated s/he had read somewhere on the internet that residential care staff under the age of 18 could work for community based residential facilities (CBRFs). Administrator A, Licensee B and Manager C acknowledged Caregiver F employment was in direct violation of DHS Chapter 83.

On 12/26/2024 at 11:20 AM, Surveyor spoke with Caregiver F over the phone. Caregiver F stated s/he disclosed s/he was under the age of 18 to Licensee B and Manager C when s/he was hired on 11/12/2024. Caregiver F stated when Licensee B hired Administrator A. Manager C had told Caregiver F that Administrator A had figured out how to make it legal for Caregiver F to work at the facility. Caregiver F stated that after Surveyor visit

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N 218	Continued From page 17 on 12/18/2024. Manager C had called him/her and had yelled at him/her for telling people his/her age. Caregiver F stated with Manager C not disclosing to him/her that his/her employment was not legal and then yelling/blaming Caregiver F for telling the truth s/he decided to put in his/her 2 weeks' notice. Caregiver F stated that s/he worked night shift on 12/20/2024 and 12/21/2024. Caregiver F stated s/he was the only staff on duty both nights. Caregiver F added Licensee B and Manager C were aware individuals under the age of 18 were not permitted to work nighttime hours, but they would schedule him/her for night shift anyway. CROSS REFERENCE N0196 DHS Chapter 83.14(2)(a) Licensee Ensures Facility Complies With Laws CROSS REFERENCE N0219 DHS Chapter 83.17(1) Licensee Conduct Caregiver Background Check CROSS REFERENCE N0397 DHS Chapter 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake	N 218		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch.	N 219		

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N 219	Continued From page 18 DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure to conduct and document caregiver background checks on 3 of 4 employee reviewed, following the procedures in s. 50.065, Stats., and ch. DHS 12. FINDINGS INCLUDE: Facility was granted a probationary license on 07/18/2024. The facility was licensed as 12-bed, non-ambulatory, community based residential facility (CBRF). Facility provided care to the following client groups: terminally ill, developmentally disabled, traumatic brain injury (TBI), physically disabled, advanced aged, irreversible dementia & Alzheimer's. On 11/27/2024, the department received a complaint which alleged misappropriation. On 12/18/2024, Surveyor arrived at facility for a complaint investigation. On 12/18/2024, Surveyor reviewed, "WISCONSIN CAREGIVER BACKGROUND CHECK AND MISCONDUCT PROGRAM MANUAL." The introduction to the manual stated, "This manual provides detailed information about the Caregiver Law as it relates to Division of Quality Assurance (DQA) regulated entities. Although the law applies to all entities regulated by the Department of Health Services (DHS), this	N 219		

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N 219	Continued From page 19	N 219		

manual focuses on entities regulated by DQA. The manual is intended to provide clear direction to these entities." Listed are the Wisconsin administrative codes from DHS chapter 50 and DHS Chapter 12 summarized in the program manual:

- "Wis. Stat. § 50.065(3)(b) ... BACKGROUND CHECK PROCESS ... Since October 1, 1998, entities have been required to complete caregiver background checks on all new caregivers. After the initial background check at the time of employment or contracting, entities must conduct new caregiver background checks at least every four years or at any time within that period that an entity has reason to believe new checks should be obtained.

- "Wis. Admin. Code § DHS 12.03(3) ... CONDUCTING CAREGIVER BACKGROUND CHECK... At a minimum, a complete caregiver background check completed for a caregiver consists of the following three documents: 1. A completed DHS form F-82064, Background Information Disclosure (BID); 2.. A response from the Department of Justice (DOJ), either A "no record found" response or A criminal record transcript; and 3. A Governmental Findings Report (previously "IBIS letter") from DHS that reports the person's status, including administrative finding or licensing restrictions. Other documentation must be obtained by the entity as required to complete the caregiver background check when applicable. Other required documentation includes: 4. If applicable (see chapter 4) arrest and conviction disposition information from local clerks of courts or tribal courts 5. If applicable (see 2.2.2.2) other state's or US jurisdiction's conviction records 6. If applicable (see 2.2.2.3) military discharge

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N 219	Continued From page 20 papers.". -"Wis. Stat. § 50.065(2)(d) Wis. Admin. Code § DHS 12.10 ... BACKGROUND CHECK RECORD RETENTION ... Entities must maintain the background check documents (see section 2.2.1.5) for each caregiver. The entity may determine where and how these records are maintained, but the records must be readily available to DQA staff upon request. In general, caregiver background checks must be retained by the entity, to document compliance with the law...". EXAMPLE 1: Administrator A On 12/18/2024, Surveyor reviewed Administrator A's staff record. Administrator A was hired on 11/18/2024. Administrator A's staff record did not contain documentation of background checks being perform at the time of hire. On 12/18/2024 at 10:20 AM, Surveyor discussed Administrator A's staff record with Administrator A. Administrator A stated provider did not conduct background checks on him/her when s/he was hired on 11/18/2024. EXAMPLE 2: Previous Caregiver D On 12/18/2024, Surveyor reviewed Previous Caregiver D's staff record. Previous Caregiver D was hired on 09/26/2024. Previous Caregiver D's department of justice (DOJ) was dated on 10/15/2024. Previous Caregiver D's staff record did not contain documentation of a state of Wisconsin department of health (DHS) caregiver background check. EXAMPLE 3: Caregiver F	N 219		

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N 219	Continued From page 21 On 12/18/2024, Surveyor reviewed Caregiver F's staff record. Caregiver F was hired on 11/12/2024. Caregiver F's staff record did not contain documentation of background checks being performed at the time of hire. According to Caregiver F's driver's license s/he was 17 years old at the time of survey. INTERVIEW: On 12/18/2024 at 4:05 PM, Surveyor discussed the above concern with Administrator A, Licensee A and Manager C. Administrator A, Licensee B and Manager C acknowledged staff background checks had not been conducted at time of hire for all employees. CROSS REFERENCE N0158 DHS Chapter 83.12(2)(a) Caregiver: Investigating Abuse & Neglect CROSS REFERENCE N0196 DHS Chapter 83.14(2)(a) Licensee Ensures Facility Complies With Laws CROSS REFERENCE N0218 DHS Chapter 83.16(2) Resident Care Staff At Least 18 Years Old CROSS REFERENCE N0348 DHS Chapter 83.32(3)(d) Rights of Residents: Freedom From Mistreatment CROSS REFERENCE N0397 DHS Chapter 83.36(1)(b) Qualified Staff in Charge On Duty And Awake	N 219		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse	N 220		

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N 220	Continued From page 22 practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating 4 of 4 employees had not been screened for clinically apparent communicable disease including tuberculosis, utilizing centers for disease control (CDC) and prevention standards within 90 days before the start of employment. On 12/18/2024, Licensee B notified Surveyor provider had been affiliated with a registered nurse (RN) since their probationary community based residential facility (CBRF) license had been granted on 07/18/2024. FINDINGS INCLUDE: On 11/27/2024, the department received a complaint which alleged misappropriation. On 12/18/2024, Surveyor arrived at facility for a complaint investigation.	N 220		

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N 220	Continued From page 23 EXAMPLE 1: Administrator A On 12/18/2024, Surveyor reviewed Administrator A's staff record. Administrator A was hired on 11/18/2024. Administrator A's staff record did not contain documentation of clinically apparent communicable disease screening nor tuberculosis (TB) laboratory results. On 12/18/2024 at 10:20 AM, Surveyor asked Administrator A if s/he had been clinically tested for tuberculosis within 90 days of hire (11/18/2024). Administrator A stated s/he had not been tested for TB within 90 days of being hired by facility. Administrator A stated s/he had not been educated on staff TB testing regulatory requirements. Administrator A stated s/he had not met a registered nurse (RN) affiliated with the facility and did not believe facility had an RN on staff. EXAMPLE 2: Previous Caregiver D On 12/18/2024, Surveyor reviewed Previous Caregiver D's staff record. Previous Caregiver D was hired on 09/26/2024. Previous Caregiver D's staff record did not contain documentation of clinically apparent communicable disease screening nor tuberculosis clinical laboratory results. EXAMPLE 3: Caregiver F On 12/18/2024, Surveyor reviewed Caregiver F's staff record. Caregiver F was hired on 11/12/2024. Caregiver F's staff record did not contain documentation of clinically apparent communicable disease screening nor TB laboratory results.	N 220		

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N 220	Continued From page 24 EXAMPLE 3: Caregiver E On 12/18/2024, Surveyor reviewed Caregiver E's staff record. Caregiver E was hired on 10/15/2024 and terminated employment on 11/23/2024. Caregiver F's staff record did not contain documentation of clinically apparent communicable disease screening nor TB laboratory results. INTERVIEW: On 12/18/2024 at 11:45 AM, Administrator A reported to Surveyor that Manager C had just texted him/her the name of the facility RN, Nurse M. Surveyor asked Administrator A to request the RN license number and contact information for Nurse M. On 12/18/2024 at 4:05 PM, Surveyor discussed the above concern with Administrator A, Licensee A and Manager C. Administrator A, Licensee B and Manager C acknowledged the staff had not been assessed by a medical professional for clinically apparent communicable disease nor received TB testing per CDC standards within 90 days before the start of employment. Licensee B stated facility was not affiliated with an RN. Licensee B stated the last time facility had an RN on staff was when the previous management company owned facility. Licensee A acknowledged facility had not been contracted with an RN since his/her probationary license was granted on 07/18/2024. CROSS REFERENCE N0196 DHS Chapter 83.14(2)(a) Licensee Ensures Facility Complies With Laws CROSS REFERENCE N0218 DHS Chapter 83.16(2) Resident Care Staff At Least 18 Years	N 220		

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N 220	Continued From page 25 Old CROSS REFERENCE N0381 DHS Chapter 83.35(1)(a) Pre-Admission And Ongoing Assessments CROSS REFERENCE N0397 DHS Chapter 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake	N 220		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the	N 310		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 310	Continued From page 26 custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not enter into a mutually agreed-upon written service agreement with residents after a change of ownership (CHOW) was finalized on 07/18/2024. On 12/28/2024 at 4:05 PM, Surveyor was notified by Licensee B that Resident 7 was the only resident who had signed an admission agreement with 1st Health LLC. Licensee B stated Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6 had not signed an admission agreement since the CHOW on 07/18/2024. FINDINGS INCLUDE: On 11/27/2024, the department received a complaint about program services at facility. On 12/18/2024, Surveyor reviewed department records. The facility underwent a change of ownership from former licensee Community Living Home Options LLC to current licensee 1st Health LLC on 07/18/2024. EXAMPLE 1: Resident 3 On 12/18/2024, Surveyor reviewed Resident 3's facility facesheet. Resident 3 was admitted to the facility on 03/31/2024. Resident 3 was discharged	N 310		

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N 310	Continued From page 27	N 310		

from the facility on 11/09/2024. Social Worker N was listed as Resident 3's managed care organization (MCO) case manager.

On 12/18/2024, Surveyor reviewed Resident 3's individualized service plan (ISP) dated 05/24/2024. Resident 3's ISP documented s/he had an activated power of attorney (APOA). Family Member J signed Resident 3's ISP and wrote, "POA," next to his/her signature.

On 12/18/2024, Surveyor reviewed Resident 3's admission agreement. Resident 3's admission agreement with former licensee Community Living Home Options LLC was signed on 03/11/2024. No, admission agreement with current licensee was on file.

EXAMPLE 2: Resident 1

On 12/18/2024, Surveyor reviewed Resident 1's facility face sheet. Resident 1 was admitted to the facility on 09/24/2021. Social Worker I was listed as Resident 1's managed care organization (MCO) case manager. No, admission agreement was documented for Resident 1.

EXAMPLE 3: Resident 4

On 12/18/2024, Surveyor reviewed Resident 4's facility facesheet. Resident 4 was admitted to the facility on 06/18/2011. Social Worker N was listed as Resident 4's MCO case manager. No, admission agreement was documented for Resident 4. .

INTERVIEWS:

On 12/18/2024 at 10:20 AM, Administrator A

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N 310	Continued From page 28 stated s/he did not have a signed admission agreement on file for Resident 1 or Resident 4. On 12/18/2024 at 4:05 PM, Surveyor discussed the above concern with Administrator A, Licensee B, and Manager C. Licensee B stated Resident 7 was the only resident who had signed an admission agreement with 1st Health LLC. Licensee B stated Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6 had not signed an admission agreement since the CHOW on 07/18/2024. On 12/19/2024 at 1:45 PM, Surveyor spoke with Social Worker N on the phone. Social Worker N stated s/he was Resident 3's & Resident 4's MCO case manager. Social Worker N denied signing an admission agreements or ISP for Resident 3 or Resident 4 since CHOW occurred on 07/18/2024. On 12/20/2024 at 10:15 PM, Surveyor spoke with Family Member J on the phone. Family Member J stated s/he was Resident 3's APOA. Family Member J denied signing an admission agreement or ISP for Resident 3 since CHOW occurred on 07/18/2024. On 12/20/2024 at 11:30 AM, Surveyor spoke with Social Worker I on the phone. Social Worker I denied signing an admission agreement or ISP for Resident 1 since CHOW occurred on 07/18/2024. CROSS REFERENCE N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 310		

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N 348	Continued From page 29	N 348		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were free from misappropriation of property. On 10/25/2024, Previous Administrator F documented Caregiver D had stolen approximately $250.00 in total from Resident 1 and Resident 2. From 10/26/2024 to 10/31/2024, Caregiver D documented administering resident medication on Resident 4's October 2024 medication administration record (MAR) on 10/26/2024, 10/27/2024, 10/29/2024, 10/30/2024, and 10/31/2024. On 11/01/2024, Licensee B reported Caregiver D to the local police department for stealing a total in $250.00 worth of cash and gifts from Resident 1 and Resident 2. Licensee B reported to the police Resident 1 and Resident 2 did not want to press charges. FINDINGS INCLUDE:	N 348		

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Facility was granted a probationary license on 07/18/2024. The facility was licensed as 12-bed, non-ambulatory, community based residential facility (CBRF). Facility provided care to the following client groups: terminally ill, developmentally disabled, traumatic brain injury (TBI), physically disabled, advanced aged, irreversible dementia & Alzheimer's.

On 11/27/2024, the department received a complaint that alleged misappropriation.

On 12/18/2024, Surveyor arrived at facility for a complaint investigation.

On 12/18/2024 at 9:30 AM, Surveyor interviewed Administrator A. Administrator A stated s/he had started his/her position on 11/18/2024. Administrator A stated s/he had been told a previous employee had stolen gift cards from Resident 1 and Resident 2. Stated s/he had not been told any more information regarding the theft.

On 12/18/2024 at 10:08 AM, Surveyor interviewed Resident 1. Resident 1 stated s/he had treated Caregiver D like a daughter. Resident 1 stated s/he had left his/her purse alone with Caregiver D on a few occasions. Resident 1 stated s/he had approximately $200.00 in cash stolen from his/her purse. Resident 1 stated s/he did not realize money had gone missing from his/her purse until a $50.00 gift card s/he had been saving for Christmas shopping went missing. Stated Caregiver D helped him/her look for the missing money. Resident 1 stated another staff member produced the missing $50.00 gift card and stated Caregiver D had given him/her the gift card to pay back a debt between them. Resident 1 stated Licensee B ended up

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N 348	Continued From page 31	N 348		

reimbursing him/her for the missing money. Resident 1 stated s/he was embarrassed due to this incident.

On 12/18/2024, Surveyor reviewed Resident 1's facility face sheet. Resident 1 was admitted to the facility on 09/24/2021. Resident 1 had an activated financial power of attorney (Family Member K) and managed care organization (MCO) case manager (Social Worker I).

On 12/18/2024, Surveyor reviewed Resident 1's incident report dated 10/25/2024. Previous Administrator F documented Caregiver D had stolen approximately $250.00 in total from Resident 1 and Resident 2.

On 12/18/2024, Surveyor reviewed Resident 4's October 2024 MAR. From 10/26/2024 to 10/31/2024, Caregiver D documented administering resident medication on Resident 4's October 2024 medication administration record (MAR) on 10/26/2024, 10/27/2024, 10/29/2024, 10/30/2024, and 10/31/2024.

On 12/18/2024 at 4:05 PM, Surveyor discussed the above concern with Administrator A, Licensee B and Manager C. Administrator A, Licensee B, and Manager C, acknowledged cash and gift cards had been misappropriated from Resident 1 and Resident 2. Licensee B and Manager C reported Caregiver D's date of termination was 11/01/2024.

On 12/20/2024, Surveyor reviewed police report #M2406466. On 11/01/2024 at 2:05 PM, Officer H documented the following, "This RO spoke with the co-owner, [Licensee B], of [Name of Previous Management Company] by phone. [Licensee B] stated that [s/he] had completed an internal

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N 348	Continued From page 32 investigation of [Caregiver D] [DOB]. [Licensee B's] investigation showed that [Caregiver D] had taken money from two residences, [Resident 2] and [Resident 1] stated that they suspected [Caregiver D] because [s/he] used a gift card with the same number as one of the victims. [Licensee B] stated that the victim's, [Resident 2] and [Resident 1], did not want [Caregiver D] charged with a crime. [Licensee B] stated the [Name of Previous Management Company] would replace the stolen money and terminate [Caregiver D]. [Licensee B] wanted an information case at the [Name of Local Police Department] to document the incident. Case Closed ...". On 12/20/2024 at 11:30 AM, Surveyor called Social Worker I. Social Worker I stated s/he had been Resident 1's MCO case manager since 2023. Social Worker I stated Resident 1 had an activated financial power of attorney who was Family Member K. Social Worker I confirmed s/he had the documentation confirming Family Member K was Resident 1's activated financial power of attorney. Social Worker I denied being notified of Resident 1's cash and gift cards being misappropriated. Social Worker I stated it was an expectation the facility would notify Resident 1's MCO case manager of misappropriation of funds. On 12/20/2024 at 3:47 PM, Family Member K called Surveyor. Family Member K stated s/he was Resident 1's activated financial power of attorney. Family Member K stated Social Worker I had just notified him/her that day of Resident 1's funds being misappropriated. Family Member K stated Resident 1 had been happier since the new owners took over this Summer. Family Member K stated s/he was surprised none of the staff called him/her to tell him/her about this.	N 348		

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N 348	Continued From page 33 CROSS REFERENCE N0170 DHS Chapter 83.12(5)(b) Notification: Abuse And Neglect Allegations CROSS REFERENCE N0196 DHS Chapter 83.14(2)(a) Licensee Ensure Facility Complies With Laws CROSS REFERENCE N0219 DHS Chapter 83.17(1) Licensee Conducts Caregiver Background Check	N 348		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment 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 record review and interview, the provider did not ensure resident 3 received prompt and adequate treatment that was appropriate to meet his/her needs. On 10/29/2024, Family Member J transported Resident 3 to an emergency room (ER). Family Member J reported facility staff had witnessed Resident 3 fall on Saturday (10/26/2024) and Sunday (10/27/2024). While in the ER Resident 3 was diagnosed with 3 different fractures on 2 ribs. Resident 3 was admitted to the hospital for the next 7 days. Family Member J discharged Resident 3 from facility on 11/09/2024 due to concern for Resident 3's safety. FINDINGS INCLUDE:	N 353		

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N 353	Continued From page 34 Facility was granted a probationary license on 07/18/2024. The facility was licensed as 12-bed, non-ambulatory, community based residential facility (CBRF). Facility provided care to the following client groups: terminally ill, developmentally disabled, traumatic brain injury (TBI), physically disabled, advanced aged, irreversible dementia & Alzheimer's. On 11/27/2024, the department received a complaint which alleged abuse. On 12/18/2024, Surveyor reviewed department records and did not find a self-report or caregiver misconduct report on file. On 12/18/2024, Surveyor arrived at facility for a complaint investigation. On 12/28/2024 at 10:00 AM, Surveyor reviewed Resident 3's facility record. Resident 3's facility record was partially on the electronic health record (EHR) and in a large filing cabinet in Administrator A's office. Administrator A handed all paper records on file for Resident 3 to Surveyor. Surveyor reviewed Resident 3's paper record. Surveyor found Resident 3's admission agreement from previous management company, incident report, and an individualized service plan (ISP). Administrator A stated s/he printed all of Resident 3's EHR records then handed Surveyor Resident 3's facility face sheet. Administrator A stated facility did not have assessments or staff notes describing Resident 3's fall and hospital admission in October 2024. Administrator A denied documentation of allegations of abuse related to Resident 3's hospital admission. On 12/18/2024, Surveyor reviewed Resident 3's	N 353		

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face sheet. Resident 3 was admitted to the facility on 03/31/2024. Resident 3 was discharged from the facility on 11/09/2024. Social Worker N was listed as Resident 3's managed care organization (MCO) case manager. Nurse O was listed as Resident 3's MCO RN (registered nurse) case manager.

On 12/18/2024, Surveyor reviewed Resident 3's individualized service plan (ISP) dated 05/24/2024. Resident 3's ISP documented s/he had an activated power of attorney (APOA). Family Member J signed Resident 3's ISP and wrote, "POA," next to his/her signature. Resident 3 was documented as, "24-hour supervision." Resident 3 utilized a walker for ambulation.

On 12/18/2024, Surveyor reviewed a facility incident report. Previous Administrator F documented the following, "INCIDENT TITLE: [Resident 3] was getting out of bed and lost [his/her] balance and slipped and fell ...CAREGIVER ON SHIFT: [Caregiver D] ...DATE OF INCIDENT: 10/30/2024 ...RESIDENT NAME: [Resident 3] ...INCIDENT DESCRIPTION: [Resident 3] was getting out of bed on [his/her] own and while trying to get off [s/he] lost [his/her] balance and fell ...We checked [him/her] and did not notice any physical injury ...We called and notified [his/her] family who came in and evaluated the situation and decided to take [Resident 3] to the hospital to be evaluated."

On 12/28/2024 at 4:05 PM, Surveyor discussed the above concern with Administrator A, Licensee B, and Manager C. Licensee B and Manager C acknowledged Resident 3 fell into a wall and was sent to an ER for treatment. Licensee B and Manager C acknowledged Resident 3 was diagnosed with approximately 3 rib fractures and

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admitted to the hospital. Licensee B and Manager C acknowledged a self-report was not sent to the department.

On 12/19/2024 at 1:45 PM, Surveyor discussed the above concern with Social Worker N. Social Worker N reported s/he had not been notified of Resident 3's rib fractures until s/he was called by the hospital.

On 12/19/2024 at 2:46 PM, Nurse O emailed Surveyor Resident 3's emergency room record dated 10/29/2024. The emergency room record documented the following, " CHIEF COMPLAINT: falls at [his/her] assisted living facility on 10/26 and 10/27...HISTORY OF PRESENT ILLNESS: Patient is a 97 year old [man/woman] with a history of dementia who currently resides at an assisted living facility. [Family Member J] is very involved in [his/her] care ... [Family Member J] gives most of the history as patient is a poor historian. [S/he] states that caregivers at [his/her] assisted living facility found [him/her] after falling onto [his/her] right side on 10/26. [S/he] had no obvious injuries at that time. [S/he] was again found on 10/27 after having a fall. Furniture was shifted and [Family Member J] presumes that [s/he] likely fell causing this to happen. Since then [s/he] has had pain in the left chest area and increasing confusion from [his/her] baseline. [S/he] is also had weakness, decreased appetite and worsened mobility from [his/her] baseline. [S/he] denies any nausea, vomiting, fevers, or urinary complaints. Workup in the emergency room was remarkable for fractures on the anterior left #3 and 4, ribs with rib #3 fractured in more than 1 place ...Because of [his/her] unsteady gait, multiple rib fractures, and weakness, it was felt that [s/he] was unsafe to return to [his/her] apartment at home ... ASSESSMENT/PLAN ...1.

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Multiple falls at independent living facility; multiple anterior left rib fractures #3 and #4: [His/Her] falls are likely due to orthostatic hypotension. We are holding Lasix and decreasing Norvasc. Will treat pain with Tylenol, lidocaine patches, and diclofenac gel ...Return to assisted living facility tomorrow as long as she is doing well. [Family Member J] involved and in agreement ...2. Altered mental status, worsening confusion with underlying dementia: Per [Family Member J] [s/he] has had worsening confusion over the last days. [S/he] seems to be improving since admission. Is likely multifactorial related to recent fall possible sleep deprivation and pain. Continue supportive care ...".

On 12/19/2024 at 3:30 PM, Surveyor called Licensee B. Surveyor asked why the facility incident report was dated for a time Resident 3 was physically at the hospital. Licensee B stated Previous Administrator F must have documented the incorrect date on the incident report. Licensee B stated s/he had not been made aware of Resident 3 falling on 10/26/2024 and 10/27/2024. Licensee B stated staff were expected to report and document all falls and injuries. Licensee B reported Family Member J had reported satisfaction with facilities care of Resident 3.

12/20/2024 at 10:15 AM, Surveyor called Family Member J. Family Member J identified themselves at Resident 3's activated power of attorney. Family Member J reported s/he hadn't met a nurse at facility since new owners bought facility. Family Member J stated the previous owner would have never hesitated to call 911, but now it seems they don't have anyone with enough medical knowledge to call 911. Stated Resident 3 wasn't getting his/her showers consistently from staff. Family Member J denied being asked to

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N 353	Continued From page 38 sign an admission agreement or ISP for Resident 3 since new owners took over facility. Family Member J reported that on 10/26/2024 during the nighttime hours. A staff member called and reported Resident 3 had fallen during a transfer and had hit their head and side on the wall as s/he fell. Family Member J stated s/he did not feel Resident 3 required emergency attention at that time. Family Member J visited Resident 3 on 10/27/2024. Family Member J reported Licensee B and Manager C seemed upset staff had told him/her Resident 3 had fallen. Family Member J stated Resident 3 appeared to have increased lethargy and depression. Family Member J reported Caregiver D had called the evening of 10/27/2024 to report Resident 3 had lost his/her balance during a transfer. Caregiver D reported Resident 3 had braced the fall with their knees. Family Member J stated s/he came back to visit Resident 3 on 10/29/2024. Family Member J found Resident 3 to be disoriented and lethargic. Family Member J reported Resident 3 seemed like they had been in pain. Family Member J then transported Resident 3 to the emergency room and diagnosed with 3 fractured ribs. Family Member J reported s/he decided Resident 3 would not be returning to facility due to lack of medical care. CROSS REFERENCE N0170 DHS Chapter 83.12(5)(b) Notification: Abuse And Neglect Allegations CROSS REFERENCE N0196 DHS Chapter 83.14(2)(a) Licensee Ensure Facility Complies With Laws CROSS REFERENCE N0381 DHS Chapter 83.35(1)(a) Pre-Admission And Ongoing Assessments	N 353		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 358	Continued From page 39	N 358		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure each resident lived in a safe environment, that safeguarded residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents 'conditions or disabilities. On 12/18/2024 from approximately 8:30 AM to 5:00 PM, Surveyor observed approximately 1-2-inch mixture of snow and ice had covered the ramps connected to the facility emergency exit front entrance, and parking lot. FINDINGS INCLUDE: Facility was granted a probationary license on 07/18/2024. The facility was licensed as 12-bed, non-ambulatory, community based residential facility (CBRF). Facility provided care to the following client groups: terminally ill, developmentally disabled, traumatic brain injury (TBI), physically disabled, advanced aged,	N 358		

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N 358	Continued From page 40	N 358		

irreversible dementia & Alzheimer's.

On 11/27/2024, the department received a complaint which alleged concerns at facility.

On 12/18/2024, Surveyor arrived at facility for a complaint investigation.

On 12/18/2024 at approximately 8:30 AM, Surveyor arrived at facility for a complaint investigation. Surveyor parked on the street due to the parking lot not being cleared of snow. Surveyor observed approximately a 1-2-inch mixture of snow and ice: on the emergency fire exit ramp, front entrance ramp, and parking lot (Picture 5 & 6).

On 12/18/2024 at 9:30 AM, Surveyor asked Administrator A who was responsible for snow/ice removal. Administrator A reported s/he did not know. Administrator A reported 4 of the 6 residents required an assistive device for ambulation. Administrator A reported s/he had emailed Manager C to find out how to get walkways and parking lot cleared of ice and snow.

On 12/18/2024 at 11:40 AM, Surveyor and Administrator A exited the facility through the front entrance. Surveyor observed the front entrance ramp, parking lot and back patio remained mostly covered in the snow/ice mixture (Picture 1 & 2). Administrator A acknowledged the walkways and parking lot to facility were not safe for those with physical disabilities to ambulate on.

On 12/18/2024 at 4:05 PM, Surveyor discussed the above concern with Administrator A, Licensee B, and Manager C. Manager C stated s/he lived in another state and so s/he did not think about

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N 358	Continued From page 41 the importance of snow removal. Licensee B reported facility did not have a contract with a snow removal company. Administrator A, Licensee B, and Manager C acknowledged 4 of their 6 current residents required an assistive device for ambulation, and this snow/ice mixture on the facility exit ramps were a hazard to their safety. At approximately 5:00 PM, Surveyor exited facility. The walkways and parking lot remained mostly covered in snow/ice. CROSS REFERENCE N0196 DHS Chapter 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 358		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident's needs, abilities, and physical and mental condition,	N 381		

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N 381	Continued From page 42	N 381		

condition before admitting the person to the CBRF and/or when there was a change in needs, abilities or condition.

On 10/26/2024 & 10/27/2024, Resident 3 experience two witnessed falls. The falls were followed by a change in Resident 3's mental status and behavior. Resident 3 was not provided a comprehensive assessment for either fall.

On 10/29/2024, Family Member J transported Resident 3 to an emergency room (ER). Resident 3 was diagnosed with 3 rib fractures and altered mental status. Resident 3 was admitted to the hospital.

FINDINGS INCLUDE:

Facility was granted a probationary license on 07/18/2024. The facility was licensed as 12-bed, non-ambulatory, community based residential facility (CBRF). Facility provided care to the following client groups: terminally ill, developmentally disabled, traumatic brain injury (TBI), physically disabled, advanced aged, irreversible dementia & Alzheimer's.

On 11/27/2024, the department received a complaint which alleged abuse.

On 12/18/2024, Surveyor reviewed department records and did not find a self-report or caregiver misconduct report on file.

On 12/18/2024, Surveyor arrived at facility for a complaint investigation.

On 12/28/2024 at 10:00 AM, Surveyor reviewed Resident 3's facility record. Resident 3's facility

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record was partially on the electronic health record (EHR) and in a large filing cabinet in Administrator A's office. Administrator A handed all paper records on file for Resident 3 to Surveyor. Surveyor reviewed Resident 3's paper record. Surveyor found Resident 3's admission agreement from previous management company, incident report, and an individualized service plan (ISP). Administrator A stated s/he printed all of Resident 3's EHR records then handed Surveyor Resident 3's facility face sheet. Administrator A stated facility did not have assessments or staff notes describing Resident 3's fall and hospital admission in October 2024. Administrator A denied documentation of allegations of abuse related to Resident 3's hospital admission.

On 12/18/2024, Surveyor reviewed Resident 3's face sheet. Resident 3 was admitted to the facility on 03/31/2024. Resident 3 was discharged from the facility on 11/09/2024. Social Worker N was listed as Resident 3's managed care organization (MCO) case manager. Nurse O was listed as Resident 3's MCO RN (registered nurse) case manager.

On 12/18/2024, Surveyor reviewed Resident 3's individualized service plan (ISP) dated 05/24/2024. Resident 3's ISP documented s/he had an activated power of attorney (APOA). Family Member J signed Resident 3's ISP and wrote, "POA," next to his/her signature. Resident 3 was documented as, "24-hour supervision." Resident 3 utilized a walker for ambulation.

On 12/18/2024, Surveyor reviewed a facility incident report. Previous Administrator F documented the following, "INCIDENT TITLE: [Resident 3] was getting out of bed and lost [his/her] balance and slipped and fell

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N 381	Continued From page 44 ...CAREGIVER ON SHIFT: [Caregiver D] ...DATE OF INCIDENT: 10/30/2024 ...RESIDENT NAME: [Resident 3] ...INCIDENT DESCRIPTION: [Resident 3] was getting out of bed on [his/her] own and while trying to get off [s/he] lost [his/her] balance and fell ...We checked [him/her] and did not notice any physical injury ...We called and notified [his/her] family who came in and evaluated the situation and decided to take [Resident 3] to the hospital to be evaluated." On 12/28/2024 at 4:05 PM, Surveyor discussed the above concern with Administrator A, Licensee B, and Manager C. Licensee B and Manager C acknowledged Resident 3 fell into a wall and was sent to an ER for treatment. Licensee B and Manager C acknowledged Resident 3 was diagnosed with approximately 3 rib fractures and admitted to the hospital. Licensee B and Manager C acknowledged Resident 3 had not been assessed by an RN or RN delegated when s/he experienced a change in condition on 10/30/2024. Licensee B stated facility had not been affiliated with an RN since s/he was granted the CBRF license on 07/18/2024. On 12/19/2024 at 2:46 PM, Nurse O emailed Surveyor Resident 3's emergency room record dated 10/29/2024. The emergency room record documented the following, " CHIEF COMPLAINT: falls at [his/her] assisted living facility on 10/26 and 10/27...HISTORY OF PRESENT ILLNESS: Patient is a 97 year old [man/woman] with a history of dementia who currently resides at an assisted living facility. [Family Member J] is very involved in [his/her] care ... [Family Member J] gives most of the history as patient is a poor historian. [S/he] states that caregivers at [his/her] assisted living facility found [him/her] after falling onto [his/her] right side on 10/26. [S/he] had no	N 381		

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obvious injuries at that time. [S/he] was again found on 10/27 after having a fall. Furniture was shifted and [Family Member J] presumes that [s/he] likely fell causing this to happen. Since then [s/he] has had pain in the left chest area and increasing confusion from [his/her] baseline. [S/he] is also had weakness, decreased appetite and worsened mobility from [his/her] baseline. [S/he] denies any nausea, vomiting, fevers, or urinary complaints. Workup in the emergency room was remarkable for fractures on the anterior left #3 and 4, ribs with rib #3 fractured in more than 1 place ...Because of [his/her] unsteady gait, multiple rib fractures, and weakness, it was felt that [s/he] was unsafe to return to [his/her] apartment at home ... ASSESSMENT/PLAN ...1. Multiple falls at independent living facility; multiple anterior left rib fractures #3 and #4: [His/Her] falls are likely due to orthostatic hypotension. We are holding Lasix and decreasing Norvasc. Will treat pain with Tylenol, lidocaine patches, and diclofenac gel ...Return to assisted living facility tomorrow as long as she is doing well. [Family Member J] involved and in agreement ...2. Altered mental status, worsening confusion with underlying dementia: Per [Family Member J] [s/he] has had worsening confusion over the last days. [S/he] seems to be improving since admission. Is likely multifactorial related to recent fall possible sleep deprivation and pain. Continue supportive care ...".

On 12/19/2024 at 3:30 PM, Surveyor called Licensee B. Surveyor asked why the facility incident report was dated for a time Resident 3 was physically at the hospital. Licensee B stated Previous Administrator F must have documented the incorrect date on the incident report. Licensee B stated s/he had not been made aware of Resident 3 falling on 10/26/2024 and 10/27/2024.

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N 381	Continued From page 46 Licensee B stated staff were expected to report and document all falls and injuries. Licensee B reported Family Member J had reported satisfaction with facilities care of Resident 3. Licensee B stated s/he would review Resident 3's facility records and forward Surveyor any staff documentation related to Resident 3's care during October 2024. On 12/20/2024, Surveyor reviewed an email from Licensee B with Resident 3's record of facility care provided in October 2024. Zero, documentation describing Resident 3's falls and subsequent mental status change on from 10/26/2024 to 10/29/2024 was reviewed. Zero, assessments of Resident 3's needs, abilities, and physical and mental condition. CROSS REFERENCE N0165 DHS Chapter 83.12(4)(c) Reporting Incidents With Serious Injury CROSS REFERENCE N0196 DHS Chapter 83.14(2)(a) Licensee Ensures Facility Complies With Laws CROSS REFERENCE N0386 DHS Chapter 83.35(3)(a) Comprehensive Individualized Service Plan	N 381		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and	N 386		

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N 386	Continued From page 47 approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a comprehensive individualized service plan (ISP) had been developed for each resident. On 12/18/2024, Surveyor discovered provider had not developed or maintained Resident 1, Resident 2, or Resident 4's ISP. Surveyor discovered caregivers did not have access to ISPs for Resident 1, Resident 2, or Resident 4 while on-site. FINDINGS INCLUDE: Facility was granted a probationary license on 07/18/2024. The facility was licensed as 12-bed, non-ambulatory, community based residential facility (CBRF). Facility provided care to the following client groups: terminally ill, developmentally disabled, traumatic brain injury (TBI), physically disabled, advanced aged, irreversible dementia & Alzheimer's. On 11/27/2024, the department received a complaint regarding program services at facility. On 12/18/2024, Surveyor arrived at facility for a complaint investigation. On 12/18/2024, Surveyor reviewed the program	N 386		

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statement for facility which documented the following, "Our Services and Goals:...The home exists to help you maintain your highest possible level of functioning. It Is our goal to promote health independence, joy, and contentment. Our services include the following: Assessment and Individualized Service Plan."

EXAMPLE 1: Resident 1

On 12/18/2024, Surveyor reviewed Resident 1's facility face sheet. Resident 1 was admitted to the facility on 09/24/2021. Resident 1 had an activated financial power of attorney (Family Member K) and managed care organization (MCO) case manager (Social Worker I). No ISP was maintained in facility EHR or paper filing system.

EXAMPLE 2: Resident 2

On 12/18/2024, Surveyor reviewed Resident 2's facility facesheet. Resident 2 was admitted to the facility on 06/12/2024. Resident 2 was documented as his/her own decision maker. The facility facesheet did not list diagnoses for Resident 2. No ISP was maintained in facility EHR or paper filing system.

EXAMPLE 3: Resident 4

On 12/18/2024, Surveyor reviewed Resident 4's facility facesheet. Resident 4 was admitted to the facility on 06/18/2011. Social Worker N was listed as Resident 4's MCO case manager. No ISP was maintained in facility EHR or paper filing system.

INTERVIEW:

On 12/18/2024 at 12:00 PM, Surveyor asked

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N 386	Continued From page 49 Administrator A for ISPs for the following residents: Resident 1, Resident 2, Resident 3 and Resident 4. Administrator A gave Surveyor the facesheets for Resident 1 thru 4. Administrator A told Surveyor s/he did not know what an ISP was, but when s/he asked Caregiver G where staff reviewed resident ISPs. Caregiver G could only produce the resident facesheets. Surveyor asked Administrator A to review Resident 1 thru Resident 4's records in the facility electronic health record (EHR). Administrator A stated s/he could not find an ISP in the facility EHR for Resident 1 thru Resident 4. Administrator A gave Surveyor all of Resident 1 thru Resident 4's paper records maintained at the facility. Surveyor could not find paper ISPs for Resident 1, Resident 2, or Resident 4. Surveyor found an ISP for Resident 3 which was developed by facilities former management company on 05/24/2024. On 12/18/2024 at 4:05 PM, Surveyor discussed the above concern with Administrator A, Licensee B, and Manager C. Administrator A asked for direction on ISP creation of residents. Surveyor encouraged Administrator A to review ISP procedures in DHS Chapter 83. Licensee B and Manager C stated they were not aware staff did not have access to Resident 1, Resident 2, and Resident 4's ISPs. Licensee B and Manager C stated meetings for legal representatives/residents to sign ISPs or admission agreements had not occurred since Licensee B and Manager C took over ownership. Administrator A, Licensee B, and Manager C acknowledged ISPs needed to be based on a comprehensive assessment. On 12/19/2024 at 1:45 PM, Surveyor spoke with Social Worker N on the phone. Social Worker N stated Resident 4's MCO case manager. Social	N 386		

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N 386	Continued From page 50 Worker N stated s/he had multiple residents placed at facility. Social Worker N stated s/he had not been asked to sign an ISP or admission agreement for residents since the new owner's took over. On 12/20/2024 at 11:30 AM, Surveyor called Social Worker I. Social Worker I stated s/he had been Resident 1's MCO case manager since 2023. Social Worker I reported s/he had not been asked to sign an ISP for Resident 1 since facility changed ownership in July 2024. CROSS REFERENCE N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws CROSS REFERENCE N0386 83.35(1)(a) Pre-Admission And Ongoing Assessments	N 386		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health	N 397		

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N 397	Continued From page 51 conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure at least one qualified resident care staff was on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. From 12/18/2024 to 12/21/2024, Surveyor discovered Volunteer L had been alone in the facility with 5 residents for an unknown period on 09/17/2024 and 09/24/2024. Volunteer L was not listed on the facility staff roster. Provider did not have any background checks or TB testing maintained for Volunteer L. The singular training documented for Volunteer L was standard precautions. Licensee B stated Volunteer L had been reimbursed with gifts cards for their time at facility, but was not considered an employee. FINDINGS INCLUDE: Facility was granted a probationary license on 07/18/2024. The facility was licensed as 12-bed, non-ambulatory, community based residential facility (CBRF). Facility provided care to the following client groups: terminally ill,	N 397		

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developmentally disabled, traumatic brain injury (TBI), physically disabled, advanced aged, irreversible dementia & Alzheimer's.

On 11/27/2024, the department received a complaint which alleged misappropriation.

On 12/18/2024, Surveyor arrived at facility for a complaint investigation.

On 12/18/2024 at 2:09 AM, Administrator A stated s/he was waiting for Licensee B and/or Manager C to notify him/her of Volunteer L's start date. Administrator A stated Volunteer L was related to Previous Administrator F and had covered a few night shifts for staff. Administrator A stated Volunteer L had been the only non-resident in the facility during the night shifts s/he had covered. Administrator A stated licensee B and Manager C had wanted Volunteer L to get standard precautions training.

On 12/18/2024 at 2:25 PM, Surveyor asked for Volunteer L's record. Administrator A stated s/he did not have a record on file for Volunteer L. Administrator A stated s/he did not have background checks, TB testing, or required training on record for Volunteer L. Administrator A stated Volunteer L would be expected to call staff over from neighboring facility should residents have a care need under his/her supervision.

On 12/18/2024 at 2:30 PM, Administrator A reported to Surveyor that Manager C had asked them to remove Volunteer L completely from the staff roster, that Volunteer L wasn't a staff member.

On 12/18/2024 at 2:35 PM, Surveyor looked up Volunteer L on the UW-Green Bay community

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1ST HEALTH LLC	215 3RD ST MONROE, WI 53566

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based residential facility (CBRF) registry. Surveyor reviewed Volunteer L had been trained in standard precautions on 11/13/2024. No, other CBRF training was documented. Administrator A looked at the UW-Green Bay CBRF registry and identified the individual Surveyor had looked up was Volunteer L.

On 12/18/2024 at 2:40 PM, Surveyor called Previous Administrator F. Previous Administrator F stated Volunteer L was his/her family member. Previous Administrator F stated Volunteer L was handicapped and did not want to be classified as an employee by the facility, but s/he wanted to help on nights facility did not have regular staff to work. Previous Administrator F stated facility had reimbursed Volunteer L for their time in gift cards. Previous Administrator F stated Volunteer L was alone with residents on 2 different night shifts during September 2024. Previous Administrator F stated Volunteer L had supervised residents for approximately 2 to 8 hours per evening. Previous Administrator F acknowledged facility had not completed background checks, TB testing nor training with Volunteer F before designating him/her to supervise the overnight care of the residents. Previous Administrator F stated Volunteer L would have needed to call over staff from neighboring facility if residents had needed care.

On 12/18/2024 at 4:05 PM, Surveyor discussed the above concern with Administrator A, Licensee B and Manager C. Licensee B and Manager C acknowledged Volunteer L had been alone with residents for nights shifts during September 2024. Administrator A, Licensee B, and Manager C, acknowledged Volunteer L had not been subject to background checks, TB testing, and/or training, before supervising the care of 5

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N 397	Continued From page 54 residents without a qualified staff present. On 12/20/2024 at 11:44 AM, License B and Manager C's primary email account emailed Surveyor the following. "- The dates and hours [Volunteer L] was alone in the building with residents - -- 09/17/2024 -- 09/24/2024." CROSS REFERENCE N0196 DHS Chapter 83.14(2)(a) Licensee Ensures Facility Complies With Laws CROSS REFERENCE N0218 DHS Chapter 83.16(2) Resident Care Staff At Least 18 years Old CROSS REFERENCE N0219 DHS Chapter 83.17(1) Licensee Conduct Caregiver Background Check	N 397		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure staff documented the	N 415		

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dosage, date and time of medication taken or treatment performed in the resident record, and the medication administration record (MAR) was initialed.

From 10/01/2024 to 10/31/2024, 28 total dosages of Resident 3 and Resident 4's prescription medications were not documented on their October 2024 MARs.

FINDINGS INCLUDE:

Facility was granted a probationary license on 07/18/2024. The facility was licensed as 12-bed, non-ambulatory, community based residential facility (CBRF). Facility provided care to the following client groups: terminally ill, developmentally disabled, traumatic brain injury (TBI), physically disabled, advanced aged, irreversible dementia & Alzheimer's.

On 11/27/2024, the department received a complaint alleging unsafe medication administration practices.

On 12/18/2024, Surveyor arrived at facility for a complaint investigation.

EXAMPLE 1: Resident 4

On 12/18/2024, Surveyor reviewed Resident 4's facility record. Resident 4 was admitted to the facility on 06/18/2011. Social Worker N was listed as Resident 4's MCO case manager. Resident 4 was diagnosed with but not limited to: dementia.

On 12/18/2024, Surveyor reviewed Resident 4's October 2024 medication administration record (MAR). The following intervals did not contain documentation of refusal or administration of

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prescription medication:
1.) 10/04/2024 at 8:00 PM - Nystatin 100,000 Units/GM powder
2.) 10/11/2024 at 8:00 PM - Nystatin 100,000 Units/GM powder
3.) 10/11/2024 at 8:00 PM - Memantine 10 mg tablet
4.) 10/11/2024 at 8:00 PM - Buspirone 7.5 mg tablet
5.) 10/11/2024 at 8:00 PM - Docusate Sodium 100 mg tablet
6.) 10/11/2024 at 8:00 PM - Senna 8.6 mg tablet
7.) 10/11/2024 at 8:00 PM - Mirtazapine 7.5 mg tablet
8.) 10/11/2024 at 8:00 PM - Trazodone 50 mg tablet
9.) 10/11/2024 at 8:00 PM - Ropinirole 1 mg tablet
10.) 10/11/2024 at 8:00 PM - Eliquis 5 mg tablet
11.) 10/17/2024 at 8:00 PM - Nystatin 100,000 Units/GM powder
12.) 10/18/2024 at 8:00 PM - Nystatin 100,000 Units/GM powder
13.) 10/24/2024 at 8:00 PM - Nystatin 100,000 Units/GM powder
14.) 10/28/2024 at 8:00 PM - Nystatin 100,000 Units/GM powder
15.) 10/31/2024 at 8:00 PM - Nystatin 100,000 Units/GM powder

On 12/18/2024 at 3:49 PM, Surveyor discussed the above concern with Administrator A. Administrator A acknowledged Resident 4's October 2024 MAR was missing documentation for 15 dosages of prescription medication. Administrator A reviewed EHR and stated s/he did not see anything documented that would explain why staff didn't initial/document in Resident 4's October 2024 MAR.

EXAMPLE 2: Resident 3

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N 415	Continued From page 57 On 12/18/2024, Surveyor reviewed Resident 3's facility face sheet. Resident 3 was admitted to the facility on 03/31/2024. Resident 3 was discharged from the facility on 11/09/2024. Social Worker N was listed as Resident 3's managed care organization (MCO) case manager. On 12/18/2024, Surveyor reviewed Resident 3's individualized service plan (ISP) dated 05/24/2024. Resident 3's ISP documented facility staff were to administer Resident 3's medications. On 12/23/2024, Surveyor reviewed Resident 3's October 2024 medication administration record (MAR). Surveyor reviewed the following intervals did not contain documentation of refusal or administration of prescription medication: 1.) 10/11/2024 at 4:00 PM - Omeprazole DR 40 mg capsule 2.) 10/11/2024 at 8:00 PM - Simvastatin 20 mg tablet 3.) 10/11/2024 at 8:00 PM - Famotidine 20 mg tablet 4.) 10/11/2024 at 2:00 PM - Acetaminophen 500 mg tablet 5.) 10/11/2024 at 8:00 PM - Acetaminophen 500 mg tablet 6.) 10/11/2024 at 2:00 PM - Diclofenac Sodium 1% gel 7.) 10/11/2024 at 8:00 PM - Diclofenac Sodium 1 % gel 8.) 10/13/2024 at 8:00 PM - Simvastatin 20 mg tablet 9.) 10/11/2024 at 8:00 PM - Famotidine 20 mg tablet 10.) 10/11/2024 at 8:00 PM - Acetaminophen 500 mg tablet 11.) 10/11/2024 at 8:00 PM - Diclofenac Sodium 1 % gel	N 415		

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N 415	Continued From page 58 12.) 10/18/2024 at 4:00 PM - Omeprazole DR 40 mg capsule 13.) 10/24/2024 at 8:00 PM - Omeprazole DR 40 mg capsule On 12/23/2024 at 2:04 PM, Surveyor email Licensee B and Manager C requesting clarification on the intervals of documentation missing from Resident 3's October 2024 MAR. On 12/24/2024 at 2:40 PM, Licensee B sent Surveyor an email with information about intervals of Levothyroxine and Omeprazole which were ordered as 'held.' Licensee B did not provide information about the intervals on the MAR which had been left blank. On 12/26/2024 at 9:28 AM, Surveyor sent Licensee B and Manager C an email clarifying his/her definition of 'missing documentation' versus 'hold order' for Resident 3's MAR. On 12/27/2024 at 9:53 AM, Licensee B emailed Surveyor and acknowledged the above documentation was missing from Resident 3's October 2024 MAR. CROSS REFERENCE N0196 DHS Chapter 83.14(2)(a) Licensee Ensures Facility Complies With Laws CROSS REFERENCE N0353 DHS Chapter 83.32(3)(i) Rights Of Residents: Adequate Treatment CROSS REFERENCE N0381 DHS Chapter 83.35(1)(a) Pre-Admission And Ongoing Assessments	N 415		

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N 427	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not arrange adequate leisure time activities for residents. On 12/18/2024, Surveyor discovered facility did not have a staff member designated to plan, organize, and encourage residents to participate in a daily leisure time activity. Administrator A did not have an activity schedule developed or posted in a resident common area. FINDINGS INCLUDE: On 11/27/2024, the department received a complaint regarding program services at facility. On 12/18/2024, Surveyor arrived at the facility at 8:35 AM and left at 5:05 PM. Surveyor did not observe leisure time activities offered to residents during this visit.	N 427		

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N 427	Continued From page 60 On 12/18/2024 at 1:30 PM, Surveyor requested facility leisure time activity schedule from Administrator A. Administrator A reported s/he was not aware leisure time activities were a regulatory requirement. Administrator A stated s/he had not observed leisure time activities offered to residents s/he started employment on 11/18/2024. Administrator A stated facility did not have a staff designated as an 'activity director.' Administrator A stated s/he did not have an activity schedule written up or posted for residents. On 12/18/2024, Surveyor reviewed the program statement for facility. The facility program statement documented the following, "Daily stimulating activity program lead by our resident care team." On 12/18/2024 at 4:05 PM, Surveyor discussed the above concern with Administrator A, Licensee B, and Manager C. Administrator A, Licensee B, and Manager C, acknowledged facility did not provide a leisure time activity to residents as described in the facility program statement. Administrator A, Licensee B, and Manager C, acknowledged facility did not have a staff designated to plan, organize, and encourage, residents to participate in daily leisure time activities. Administrator A, Licensee B, and Manager C, acknowledged facility had not developed or posted an activity schedule for residents and Surveyor to review. CROSS REFERENCE N0196 DHS Chapter 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 427		