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	0012702	A. BUILDING: _____ B. WING _____	R-C 09/13/2024

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HOMETOWN SENIOR LIVING	1015 CREST VIEW DR HUDSON, WI 54016

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{M 000}	INITIAL COMMENTS On 09/11/2024, Surveyor conducted a complaint investigation, verification visit, and standard licensing survey at Hometown Senior Living. Data was collected through 09/13/2024. Three of 3 complaints were substantiated. Fourteen violations were identified. Five of 14 violations were repeat deficiencies. See Statement of Deficiencies (SOD) E3GH11, dated 05/18/2022 and SOD E3GH12, dated 06/27/2023. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 2	{M 000}		
M 114	88.03(3)(b) CRIMINAL RECORDS CHECK Criminal records check. Prior to an initial license the licensing agency shall ask the Wisconsin department of justice to conduct a criminal records check on the license applicant and on any other adult household member. The licensee shall arrange for a criminal records check of all service providers. At least every second year following issuance of an initial license the licensing agency shall request a criminal records check on the licensee and all other adult household members and the licensee shall arrange for a criminal records check on any service provider. In addition, during the period of the licensure, the licensee shall arrange for a criminal records check on any	M 114		

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

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M 114	Continued From page 1	M 114		

new service provider. If any of these persons has a conviction record or a pending criminal charge which substantially relates to the care of a dependent population, the funds or property of adults or minors or activities of the adult family home, the licensing agency may deny, revoke, refuse to renew or suspend a license, initiate other enforcement action provided in this chapter or in ch. 50, Stats., or place conditions on the license.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not complete a caregiver background check for 1 of 4 employees (Caregiver E) sampled.

Findings include:

On 09/11/2024 and 09/12/2024, Surveyor reviewed employee records. Caregiver E was hired on 04/13/2022. Caregiver E's record did not include evidence of a Wisconsin caregiver background check.

On 09/12/2024 at 1:10 PM, Surveyor sent Executive Director (ED) A, Director of Marketing (DM) B, and Manager C an email inquiring if the provider (a Minnesota-based corporation) conducted Wisconsin caregiver background checks on their employees. ED A replied at 1:20 PM, "I just spoke with HR and they are getting the

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M 114	Continued From page 2 information." As of 09/13/2024, Surveyor did not receive evidence of Caregiver E's Wisconsin caregiver background check.	M 114		
M 204	88.03(8)(a) MONITORING OF HOME The licensee shall comply with all department and licensing agency request for information about residents, services or operation of the home. This Rule is not met as evidenced by: Based on interview and record review, the provider did not comply with all Department requests for information, which delayed the survey process. Findings include: On 09/11/2024 at approximately noon, Surveyor requested resident records from Executive Director (ED) A, Director of Marketing (DM) B, Manager C, and House Manager (HM) D. Manager C stated resident records were electronic and they could not give Surveyor access to the electronic system. Manager C stated they would send the complete resident records to Surveyor via email. At 12:56 PM, Surveyor provided a written list to ED A, Manager C, and HM D of the resident records needed for review. Surveyor discussed each item on the list, and asked if they had any questions about what Surveyor was requesting. The managers stated they had no questions and	M 204		

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M 204	Continued From page 3 agreed to get Surveyor the documents by the end of the business day. The list of requests included the following documents for Resident 1, Resident 2, and Resident 3: - Evacuation assessments - Medication administration records (MAR) for June through September - Task charting for June through September - All progress notes for June through September As of 09/12/2024 at 6:00 AM, Surveyor had received partial records via email. On 09/12/2024 at 11:50 AM, Surveyor interviewed ED A. Surveyor informed ED A that many of the requested records were not received. ED A stated s/he would follow up with DM B and Manager C. On 09/12/2024 at 12:53 PM, Surveyor received an email from ED A requesting Surveyor send ED A, DM B, and Manager C a list of any documents not yet received. Surveyor replied at 1:10 PM, requesting the following records for Resident 1, Resident 2, or Resident 3: - Evacuation assessments - June and July MARs - June and July task administration records (TAR) - Staff progress notes for June through September - Written authorizations to administer medications per 88.07(3)(d) At 2:07 PM, Surveyor received an email from ED A with Resident 2's and Resident 3's June and July MARs. ED A stated they were having trouble accessing the records for discharged residents. The provider was able to access discharged resident records on 09/11/2024.	M 204		

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M 204	Continued From page 4 At 3:57 PM, Surveyor sent ED A an email indicating Surveyor had not received the requested records and questioning whether or not they were working on sending additional documents for review. At 4:46 PM, ED A included Surveyor in an email to Manager C that read, "[Manager C], Can you please follow up with [Surveyor] to see either what is missing and/or if you were able to get the records for the discharged resident." As of 4:55 PM, Surveyor sent ED A, DM B, and Manager C an email asking for clarification as to why they could access discharged resident records on 09/11/2024. DM B responded at 5:01 PM, indicating s/he was unsure. Surveyor asked if there was a reason the current resident records were not sent. Surveyor provided a final list of the missing document requests and asked that the provider indicate in a reply if they did not have the documents. On 09/13/2024, Surveyor received multiple emails from the provider between 10:29 AM and 1:28 PM that included various resident documentation. Surveyor reviewed the documentation and found the following requested documents were missing; the provider did not indicate if these documents existed or not, as requested: - Resident 3's evacuation assessment. - Resident 1's June task administration record. - Resident 3's written authorization to administer medications. Multiple requests were made for documentation needed to complete the complaint investigations and licensure survey. The provider did not provide the requested documents or	M 204		

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M 204	Continued From page 5 communicate with Surveyor if they did not have the documents. This delayed the survey process.	M 204		
M 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on observation, interview, and record review, the licensee did not ensure the home and its operation complied with all laws governing the operation. Findings include: The provider is licensed to care for 4 residents in the client groups physically disabled and advanced aged. On 08/15/2023, the Department issued Statement of Deficiencies (SOD) E3GH12 that included 5 violations. The provider was ordered to correct the deficiencies and maintain compliance by 09/29/2023. Between June and July 2024, the Department received 3 complaints related to staff training and resident care. Between 09/11/2024 to 09/13/2024, the Department conducted an investigation and verification visit to ensure the violations from the previous survey were corrected. Three of 3 complaints were substantiated, and 3 of the 5 deficiencies cited in the last survey were not	M 216		

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corrected. The following is a list of the issues identified during the survey:
- The provider did not complete Wisconsin caregiver background checks.
- The provider did not request out-of-state criminal history reports for employees who resided outside Wisconsin within 3 years from the date of hire.
- Leadership failed to provide the Department with requested records to complete the survey timely.
- Staff were not screened for communicable disease prior to working with residents. This issue was first identified in 2022 and was found to be uncorrected at a visit in 2023. See SOD E3GH11, dated 05/18/2022 and E3GH12, dated 06/27/2023.
- Staff did not complete required initial training within 6 months of hire. This was a repeat deficiency; see SOD E3GH11.
- Staff did not complete required continuing education.
- The home did not have required fire protection systems (i.e. smoke detectors or smoke detector maintenance).
- Resident evacuation capabilities were not assessed annually. This was a repeat deficiency; see SOD E3GH11.
- Residents were not provided services that met their needs. This was a repeat deficiency; see SOD E3GH12.
- Medications were not stored securely.
- Confidential resident records were not stored securely.
- The provider did not obtain a written order from resident physicians prior to administering medications. This was identified SOD E3GH12 and SOD E3GH11.

On 09/11/2024 at 9:00 AM, Surveyor was notified

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by House Manager (HM) D that the provider planned to close the location on 09/20/2024. HM D stated each home had an executive director (ED) and HM, but these positions also oversaw multiple facilities. At 10:15 AM, Surveyor met with Executive Director (ED) A. ED A stated s/he was filling in for the facility's ED because s/he was still in training. ED A discussed not being familiar with Wisconsin assisted living rules because s/he oversaw the provider's Minnesota homes. ED A stated HM D was new to his/her position, so the person responsible for the home's compliance was Director of Marketing (DM) B.

At 10:33 AM, Surveyor interviewed Resident 2. Resident 2 stated s/he lived at the facility over 10 years. Resident 2 discussed being dissatisfied with the corporation and staff. Resident 2 stated, "It's been awful... they just put a body here... the ones (staff) that do care for us, they leave because [licensee] doesn't support them." Resident 2 stated managers were only on site 1 time per week to do inventory. Resident 2 stated staff filled in from the provider's Woodbury location, they did not know the resident's needs or preferences, and nobody was checking on them. Resident 2 stated, "Staff come, they cook us a meal and give us meds (medications). Other than that, they sit. One actually comes and hooks up a gaming device!"

At 11:06 AM, Surveyor interviewed Caregiver J. Caregiver J discussed concerns about some of the staff's work ethic. Caregiver J stated there were overnight staff that did not do their assigned tasks. Caregiver J stated Resident 3 reported to Caregiver J that staff did not come when s/he pushed his/her call pendent. Caregiver J stated s/he believed this was true because on these days s/he had to change Resident 3's bedding

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because s/he soaked through his/her brief and clothing. Caregiver J stated s/he reported this to House Manager (HM) D and Resident 3's social worker.

At 12:56 PM, Surveyor interviewed Executive Director (ED) A, House Manger (HM) D, and Manager C. Surveyor asked each manager individually if anyone brought concerns to their attention regarding resident care within the past 3 months. ED A and HM D stated they were not aware of any resident care concerns. Manager C stated a past resident's family (Resident 1) had concerns that Resident 1's tasks were not being completed. Manager C stated, "Services were completed because they were checked off." ED A stated the HM was responsible for supervising the daily program, which included reviewing staff charting to ensure services were completed per each resident's care plan. ED A stated managers were not onsite daily.

Cross references:
M0114 DHS 88.03(3)(b) Criminal Records Check
M0204 DHS 88.03(8)(a) Monitoring Of Home
M0232 DHS 88.04(2)(g)1 Health Screening For Staff
M0244 DHS 88.04(5)(a) Training-15 Hours Within 6 Months
M0246 DHS 88.04(5)(b) Training-8 Hours Annually
M0334 DHS 88.05(4)(b)1 Fire Safety-Smoke Detectors
M0336 DHS 88.05(4)(b)2 Smoke Detectors-Testing And Maintenance
M0346 DHS 88.05(4)(d)2.b Fire Evacuation Annual Evaluation
M0438 DHS 88.07(2)(b) Services Directed To Goals
M0458 DHS 88.07(3)(a) Prescription Medications

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M 216	Continued From page 9 M0464 DHS 88.07(3)(d) Medication- Written Order M0482 DHS 88.09(1)(a) Resident Records M0012 Wis. Stat. ch. 50.065(2)(bm) Out Of State Background Checks	M 216		
{M 232}	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 4 staff (Caregiver E, Caregiver F, Caregiver G, and Caregiver H) reviewed, were screened for communicable disease. This is a repeat deficiency. See Statement of Deficiency (SOD) E3GH11, dated 05/18/2022, and SOD E3GH12, dated 06/27/2023. Findings include: On 09/11/2024 and 09/12/2024, Surveyor reviewed employee records. Three of the records (Caregiver F, Caregiver G, and Caregiver H)	{M 232}		

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{M 232}	Continued From page 10 included evidence that staff were screened for tuberculosis (TB) but no other communicable diseases. One record (Caregiver E) did not have evidence of any communicable disease screening. The following files were reviewed: - Caregiver E, hired on 04/13/2022 - Caregiver F, hired on 02/12/2024 - Caregiver G, hired on 11/20/2023 - Caregiver H, hired on 01/02/2024 On 09/12/2024 at 1:10 PM, Surveyor sent Executive Director (ED) A, Director of Marketing (DM) B, and Manager C an email inquiring if new employees were screened for communicable diseases other than TB. ED A replied at 1:20 PM, "TB is the only communicable disease that we screen for."	{M 232}		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 4 caregivers (Caregiver E and Caregiver G) sampled, received 15 hours of training within 6 months, that included	M 244		

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resident rights, training on resident-specific needs, fire safety, and first aid. Caregiver E did not complete any required training topics. Caregiver G did not complete training on resident-specific needs such as lifts, ostomy care, catheter care, or provision of personal cares.

This is a repeat violation. See Statement of Deficiencies (SOD) E3GH11, dated 05/18/2022.

Findings include:

The provider is licensed to care for 4 residents in the client groups physically disabled and advanced aged.

Between June and July 2024, the Department received 3 complaints related to resident care and staff competency.

On 09/11/2024 at 9:00 AM, Surveyor interviewed House Manager (HM) D. HM D provided a brief overview of the resident needs in the home. HM D stated Resident 2 and Resident 3 required transfer assistance from bed to electric wheelchairs. Resident 2 required a mechanical ceiling lift for transfers and Resident 3 preferred a gait belt transfer. HM D stated Resident 2 was able to assist with his/her personal cares, but required staff to hand him/her supplies, and Resident 3 was considered a full assist with his/her dressing, showering, and incontinence care. HM D stated both residents required medication management and administration assistance.

On 09/12/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 04/01/2021 and discharged on 08/01/2024. According to Resident 1's individual service plan (ISP), dated

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07/01/2024, Resident 1 required assistance with his/her catheter (emptying, changing the bag, and cleaning) and ostomy bag (emptying the bag, cleansing the area/connection, and monitoring output).

According to the staff schedule, staff worked alone at the facility on each shift. Caregiver E and Caregiver G worked at the facility during Resident 1's placement.

On 09/11/2024 and 09/12/2024, Surveyor reviewed employee records.

Caregiver E was hired on 04/13/2022. Caregiver E's record did not include evidence s/he completed training within 6 months of hire.

Caregiver G was hired on 11/20/2023. Caregiver G's record indicated s/he completed a training on choking, but there was no evidence s/he was trained on other first aid measures. Caregiver G's training record did not indicate s/he completed training on resident-specific needs such as personal care tasks, transfer assistance, catheter care, or ostomy care.

On 09/12/2024 at 10:22 AM, Surveyor sent Executive Director (ED) A and Director of Marketing (DM) B an email indicating staff records were not complete. Surveyor asked if the provider had any additional records for review. The provider replied with a large file titled "trainings" at 3:37 PM. The record did not include evidence Caregiver E or Caregiver G completed the required trainings reference above.

On 09/12/2024 at 12:49 PM, Surveyor interviewed Caregiver G. Caregiver G stated, "I kind of trained myself... The [staff] that was

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M 244	Continued From page 13 supposed to train me, didn't want to train me." Caregiver G stated s/he received the provider's corporate training at the provider's headquarters in Minnesota but s/he did not receive any site-specific training. Caregiver G explained that the residents taught Caregiver G about their care needs.	M 244		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Caregiver E completed 8 hours of continuing education in 2023. Findings include: The provider is licensed to care for 4 residents in the client groups physically disabled and advanced aged. Between June and July 2024, the Department received 3 complaints related to resident care and staff competency. On 09/11/2024 at approximately 12:30 PM,	M 246		

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M 246	Continued From page 14 Surveyor requested Caregiver E's record for review. According to the staff roster, Caregiver E was hired on 04/13/2022. On 09/12/2024 at 11:50 AM, Surveyor interviewed Executive Director (ED) A. ED A stated they were still trying to locate Caregiver E's training record. On 09/12/2024 at 10:22 AM, Surveyor sent Executive Director (ED) A and Director of Marketing (DM) B an email indicating staff records were not complete. Surveyor asked if the provider had any additional records for review. The provider replied with a large file titled "trainings" at 3:37 PM. The record indicated Caregiver E completed the following trainings since hire: - Employee Benefits on 08/30/2024 - Fraud, Waste, and Abuse on 08/30/2024 - Corporate Compliance on 08/30/2024 - HIPAA and Confidentiality on 09/02/2024	M 246		
M 334	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in	M 334		

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M 334	Continued From page 15 the basement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure every habitable room, except the kitchen and bathroom, had a smoke detector. Findings include: On 09/11/2024, Surveyor toured the facility and found the following areas to not have a smoke detector: - Dining room - Upstairs living room - At the head of the enclosed stairway to the basement - Basement lounge/living area - Basement storage/utility area - Resident bedroom next to the kitchen bathroom - Sun room - Woodworking shop The following areas had a smoke detector on the wall, not on the ceiling: - Library/lounge - Hallway leading to resident bedrooms At 9:37 AM, House Manager (HM) D stated the provider recently replaced the facility's smoke detectors. At 12:44 PM, Executive Director (ED) A informed Surveyor that Maintenance Director (MD) I removed expired smoke detectors and reinstalled new ones in July 2024.	M 334		

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M 336	Continued From page 16	M 336		
M 336	88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is operating. If a unit is found to be not operating, the licensee shall immediately replace the battery or have the unit repaired or replaced. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure smoke detectors were tested monthly. Findings include: On 09/11/2024, Surveyor reviewed the provider's smoke detector maintenance logs from 2024, which indicated the provider had not tested or maintained the smoke detectors since May 2024. At 12:44 PM, Surveyor interviewed Executive Director (ED) A. ED A stated Maintenance Director (MD) I was new to his/her position and s/he did not know to document when s/he checked the smoke detectors. ED A stated MD I replaced the facility's smoke detectors in July 2024. According to the staff roster provided on 09/11/2024, MD I was hired on 05/15/2024.	M 336		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION	M 346		

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M 346	Continued From page 17 Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 residents sampled (Resident 1, Resident 2, and Resident 3), were evaluated annually for evacuation capabilities. This is a repeat violation. See Statement of Deficiencies (SOD) E3GH11, dated 05/18/2022. Findings include: On 09/11/2024 and 09/12/2024, Surveyor requested resident evacuation assessments for review from Executive Director (ED) A, Director of Marketing (DM) B, and Manager C. On 09/13/2024, after the survey had closed, Surveyor received an email from ED A that read, "Sorry for the delay and any inconvenience." The email included 2 of the 3 requested evacuation assessments. On 09/13/2024, Surveyor reviewed resident records. Resident 3 was admitted on 08/27/2023. Resident 3's record did not include an evacuation assessment. Resident 2 was admitted on 12/18/2013. Resident 2's last evacuation assessment was	M 346		

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M 346	Continued From page 18 completed on 05/15/2023. Resident 1 was admitted on 04/01/2021 and discharged on 08/01/2024. Resident 1's last evacuation assessment was dated 05/15/2023. The assessment indicated Resident 1 required assistance of 1 staff to complete an evacuation. Resident 1's progress notes indicated Resident 1 had an occupational therapy (OT) assessment on 04/29/2024. Surveyor reviewed the OT assessment, dated 04/30/2024. The OT assessment read, "Pt (patient) requires 2 CG (caregivers) for all transfers for safety of patient and CG. LM (left message) for facility nurse; awaiting return call."	M 346		
{M 438}	88.07(2)(b) SERVICES DIRECTED TO GOALS Services shall be directed to the goal of assisting, teaching and supporting the resident to promote his or her health, well-being, self-esteem, independence and quality of life. The services shall include but are not limited to: This Rule is not met as evidenced by: Based on interview, observation, and record review, the provider did not ensure residents received services that supported health, well-being, self-esteem, independence, and quality of life. Resident 1 did not receive transfer assistance, wound care, or personal care services to meet his/her needs. Resident 3 did not receive incontinence care or dressing assistance to meet his/her needs.	{M 438}		

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{M 438}	Continued From page 19 This is a repeat violation. See Statement of Deficiencies (SOD) E3GH12, dated 06/27/2023. Findings include: The provider is licensed to care for 4 residents in the client groups physically disabled and advanced aged. Between June and July 2024, the Department received 3 complaints related to staff training and resident care. RESIDENT 1 On 09/11/2024 at approximately 9:15 AM, Surveyor interviewed House Manager (HM) D. HM D stated the provider scheduled 1 caregiver per shift. Surveyor reviewed the staff schedule for dates 03/01/2024 through 09/11/2024, provided by Executive Director (ED) A. The schedule confirmed 1 staff per shift. A second caregiver was on site twice a week during part of the morning shift. On 09/11/2024 at 12:56 PM, Surveyor interviewed Executive Director (ED) A, HM D, and Manager C. Surveyor asked each manager individually if anyone brought concerns to their attention regarding resident care, within the past 3 months. ED A and HM D stated they were not aware of any resident care concerns. Manager C stated Resident 1's family had concerns that Resident 1's tasks were not completed. Manager C stated, "Services were completed because they were checked off." On 09/13/2024, Surveyor reviewed records	{M 438}		

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{M 438}	Continued From page 20 obtained from the provider and records obtained from Resident 1's home health agency. Surveyor requested Resident 1's record from ED A, HM D, and Manager C on 09/11/2024, 09/12/2024 and 09/13/2024. Requested documentation included Resident 1's June and July task administration record (TAR) and all staff progress notes from June through discharge. Surveyor received Resident 1's July TAR and did not receive the staff notes as requested. Resident 1 was admitted to the facility on 04/01/2021, and discharged on 08/01/2024. Resident 1's diagnoses included multiple sclerosis, paraplegia, and major depressive disorder. Resident 1's individual service plan (ISP), updated 07/01/2024, indicated Resident 1 required the following: - Dressing assistance daily in the morning and evening. This service was effective 04/01/2021. - Grooming assistance daily in the morning and evening; "Unlicensed assistive personnel to groom resident (wash face, brush hair, and brush teeth.)". This service was effective 04/01/2021. - "Wound care will be maintained by the home health, hospice, or other nursing agency.. [sic] Community to provide assistance with maintaining wound integrity and will report any concerns to the agency or physician/PCP." Effective 07/02/2024. - "The Foley catheter changes will be maintained by the home health, hospice, or other nursing agency.. [sic] Community to provide assistance with maintaining catheter cleanliness and will report any concerns to the agency or physician/PCP." Effective 02/23/2022. - Catheter bag changes every day. This service was effective 02/15/2023.	{M 438}		

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{M 438}	Continued From page 21 - Catheter: Empty Bag. Effective 04/01/2021. - "Ostomy Care: Empty Appliance... Community to provide assistance with maintaining ostomy or ileostomy cleanliness and will report any concerns to the agency or physician/PCP." Effective 04/01/2021. - "Check resident for incontinence cares every 2 hours with repositioning. Check brief to make sure brief is dry to ensure suprapubic catheter is not bypassing.. Unlicensed assistive personnel to physically assist resident to use toilet, and/or change adult undergarments and provide peri care as needed... Community to provide assistance to ensure and maintain independence where possible, dignity and hygiene." Effective 06/27/20223. On 04/29/2024, Resident 1 had an occupational therapy (OT) assessment. The OT assessment read, "ASSESSED 2 PERSON-ASSIST HOYER TRANSFER FROM BED>SHOWER CHAIR. PT (patient) HAD LLE (left lower extremity) FALLING OFF BED, WHILE CG (caregiver) #2 WAS TRYING TO HOLD THE PATIENT IN SIDELYING... CG'S [sic] HAD DIFFUCLTY WITH POSITIONING PT IN SHOWER CHAIR AND MADE 5 ATTEMPTS AT REPOSITIONING. PT HAD A HEAVY LEAN TO RIGHT, SLING NOT SITUATED CORRECTLY UNDER PATIENT'S LEGS AND [s/he] STATED THAT [s/he] WAS NOT COMFORTABLE... THIS PATIENT SHOULD NOT BE TRANSFERRED WHEN THERE IS ONLY 1 STAFF MEMBER AVAILABLE... THE FACILITY ONLY HAS 1 STAFF MEMBER ON DURING DAY/NIGHT UNLESS IT'S SHOWER DAYS AND THEN THE 2ND CG IS ONLY THERE DURING SHOWER TIME." The Resident 1's OT provider notes read:	{M 438}		

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{M 438}	Continued From page 22 - "4/30/2024 10:38 AM... Focus of visit: functional transfers, safety...Pt requires 2 CG for all transfers for safety of patient and CG. LM (left message) for facility nurse; awaiting return call." - "5/7/2024 2:15 PM... Focus of visit: cognition... New issues/concerns: Pt not participating-not [him/herself]... Aides state that [s/he] has been refusing a lot of things lately. The facility no longer appears to be meeting [his/her] physical and emotional needs." The following is a summary of Resident 1's home health visit notes: - 06/05/2024 at 9:49 AM: " ...colostomy bag changed, pt had ostomy bag completely full and fecal matter coming out bottom. Dried feces around skin and bag. Unsure how long bag had been in that state." - 06/07/2024 at 11:06 AM: "Ostomy bag from Wednesdays [sic] application and little/no stool in bag. Pt (patient) denied abd (abdominal) pain or discomfort. Staff were aware and educated on when to call homecare due to no BM." - 06/12/2024 at 10:03 AM: "Ostomy bag changed after pt request. Unsure when last bag change had occurred. Dated ostomy bag ... staffing continues to be a [sic] issue with multiple new staff unaware of how to care for pts daily needs. Many cares are late or deferred to another day such as showering or changing ostomy bag." - 06/19/2024 at 11:05 AM: "Patient in bed on writer arrival. Per family and patient, cares had not yet been done this morning due to delays in staff schedule. On assessment, patient was found to have white buildup in groin folder and buildup of drainage on skin surrounding catheter. Discharge in brief which patient stated had not yet been changed this morning. Patient's catheter bag was ¾ full with [sic] urine and there was a backup of urine in the tubing all the way to the	{M 438}		

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{M 438}	Continued From page 23	{M 438}		

connection to the catheter itself. Patient denied any pain, but writer did replace bag and irrigate catheter as this had also not been done yet today on AM shift. Writer changed brief, replaced dressing to R (right) buttock/thigh that was placed to protect a fragile area and had not been changed since 6/14 per date written on bandage. Writer also replaced dressing on abdomen which was dated 6/14 as well, this area did appear to be healing well and measured smaller per history in wound assessment. Ostomy bag was quite full on assessment and had not been changed since 6/14."
- 07/12/2024 at 10:28 AM: "RN assisted with cleaning and cares, catheter cares, flushing of catheter (due to it not being completed yet), wound care and changing of ostomy bag."
- 07/24/2024 at 9:49 AM: "Pt wound dressing noted not to have been changed for 1 week (staff at facility to change bandage at least 1 other time within a week). Ostomy noted to not have much output but very watery stool. Upon inspection stool was caked on at ostomy site and pushing apart appliance. Ostomy bag changed. SP (suprapubic) catheter had gauze in place but significant build up around catheter. Collection bag not emptied and held 900cc. Discharge and foul odor noted to come from pts vaginal area, creamy white/yellow discharge noted. Pt cleansed and new brief applied. Noted several areas of fragile skin on buttocks that likly [sic] are from pinching skin during show [sic] in shower chair pt has. Large joint visit planned in 2 days with NP (nurse practitioner), facility RN and homecare RN."
- 07/26/2024 at 9:00 AM: "Visit completed with [NP L] and [Family Member (FM) M] present. Facility RN was suppose [sic] to be present but never showed up and staff at facility was unable to get in contact with D.O.N. (director of nursing)

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{M 438}	Continued From page 24 for facility. Thorough skin assessment compleded [sic]. 2 additional sacral wounds identified likely from shower chair. Skin red and raw by vaginal openings due to vaginal yeast infection. Pt cleaned and barrier cream applied to buttocks, baby powder applied to groin and under skin folds. Colostomy bag changed due to leaking and caking of feeces [sic]. NP discussed addition of another stool softener to decrease risk of caking occurrence. Pt unsure of adding that medication at this time. Dressing changed, wound area still has openings [sic] discussed with pt and NP on next steps. Recommended to be seen by wound clinic for further treatments and possible surgical intervention." - 07/26/2024 at 12:48 PM: "Contacted [provider] and requested number for facility nurse or DON. Executive Nurse line provided. Writer called nurse line and talked to nurse, Nurse N. [Nurse N] was informed that the Homecare Nurse and NP were planning to meet with the facility nurse this morning during client's visit... Writer asked to discuss some concerns that Homecare staff have been observing and reporting... Wound care not being completed. [Nurse N] states that the [sic] do not provide wound care... [Nurse N] states that they can not [sic] do routine dressing changes but can 'slap' a replacement bandage on. [Nurse N] was informed that client was previously receiving these cares through their ALF (assisted living facility). After reviewing the facility MAR (medication administration record), it appears that client has daily dressing changes scheduled... [Nurse N] was also asked if they change client ostomy bag [sic] since there have been concerns about frequency of changes as well. [S/he] states yes colostomy bag is changed once weekly. After reviewing the facility's MAR, it appears that client received 2 scheduled bag changes a week... [Nurse N] was also informed that the home care	{M 438}		

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{M 438}	Continued From page 25 agency has some concerns about frequency of showers. [Nurse N] states that an outside agency does showers. [Nurse N] was told that our agency provides showers 1 day a week and that is to supplement the care that [Resident 1] already received at the ALF... [Nurse N] was told... client is a 2 person assist. [Nurse N] was asked if there are to [sic] facility staff present on shower days to help with this. [Nurse N] states that there are 2 people present on Tuesdays and Fridays." Surveyor reviewed Resident 1's July 2024 TAR. The TAR indicated Resident 1 was scheduled to receive bathing assistance 2 times a week. It is unclear if the task was completed as the staff's initials were circled, indicating staff charted additional notes. Other scheduled care tasks such as catheter bag changes, emptying the catheter bag, dressing assistance, grooming assistance, ostomy care (emptying appliance), and 2-hour checks, were inconsistently charted as complete. The TAR had a significant number of blanks. The provider did not meet Resident 1's care needs. Adequate staff were not provided to safely transfer Resident 1 and scheduled care tasks were not provided based on Resident 1's home health agency's observations and provider charting. Concerns were brought to the provider's attention, and the provider determined cares were completed based on staff's incomplete charting. RESIDENT 3 On 10/16/2023, the Department received a self-report indicating an overnight shift caregiver did not check or change resident on 10/08/2024. The report indicated Resident 3 required a "complete bed change. [S/he's] very very upset I	{M 438}		

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{M 438}	Continued From page 26 cannot express this enough [s/he] doesn't help [Resident 3] at all when [s/he] works." On 09/11/2024 at 9:49 AM, Surveyor interviewed Resident 3. Resident 3 stated s/he had lived at the facility for about 1 year and s/he was moving out today. Resident 3 stated s/he needed assistance getting from his/her bed to his/her electric wheelchair. Resident 3 explained s/he also needed staff assistance with dressing, showering, and changing his/her incontinence brief. Surveyor asked how often s/he received these services. Resident 3 replied that s/he was supposed to get showers 2 times a week, but that did not always happen. Resident 3 said s/he had gone over a week before without a shower. S/he stated, "Before, they would say I would refuse, but I never have. They used that as an excuse." Resident 3 stated staff only changed his/her clothing on shower days. Surveyor asked if staff changed him/her into pajamas and Resident 3 stated s/he remained in the same clothing until shower day. Staff asked if Resident 3 was satisfied with the care s/he received at the facility, and Resident 3 stated s/he was in the beginning, but it had been "hit or miss" lately. Resident 3 stated, "There's always someone here... a lot of them (staff) sit and watch TV." Surveyor asked Resident 3 about the incident that was reported to the Department on 10/08/2023. Resident 3 replied, "That happens a lot where they don't change my brief... I've got like 2 shifts." Resident 3 stated it was not comfortable sitting in a wet or soiled brief. Resident 3 discussed giving up on ringing for staff because sometimes they did not respond. Resident 3 denied feeling neglected or mistreated but stated s/he wished staff would do their job and not treat residents like an inconvenience.	{M 438}		

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	0012702	A. BUILDING: _____ B. WING _____	R-C 09/13/2024

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{M 438}	Continued From page 27 At 10:33 AM, Surveyor interviewed Resident 2. Resident 2 stated s/he lived at the facility over 10 years. Resident 2 discussed being dissatisfied with the corporation and staff. Resident 2 stated, "It's been awful... they just put a body here... the ones (staff) that do care for us, they leave because [licensee] doesn't support them." Resident 2 stated staff filled in from the provider's Woodbury location, they did not know the resident's needs or preferences, and nobody was checking on them. Resident 2 stated, "Staff come, they cook us a meal and give us meds. Other than that, they sit. One actually comes and hooks up a gaming device!" Surveyor asked Resident 2 about the incident that was reported to the Department on 10/08/2023. Resident 2 stated s/he recalled the situation, and that it had happened to Resident 3 often. Resident 2 stated Resident 3 rang for staff during the day on Monday (09/09/2024) and the caregiver working told Resident 3 s/he did not know how to change Resident 3. Resident 2 stated Resident 3 sat in his/her wet brief most of the day. Surveyor reviewed the staff schedule for 09/09/2024. Caregiver J worked from 6:30 AM to 2:30 PM and Caregiver G worked from 2:30 PM to 10:45 PM. On 09/12/2024 at 12:49 PM, Surveyor interviewed Caregiver G. Caregiver G stated s/he only worked at the facility approximately 6 times but s/he did work Monday, 09/09/2024. Caregiver G stated, "I don't know [Resident 3] well... [s/he's] pretty simple." Surveyor asked if s/he recalled changing Resident 3's brief during the shift. Caregiver G stated s/he recalled Resident 3 rang	{M 438}		

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{M 438}	Continued From page 28 for him/her right before shift change. Caregiver G stated s/he could change Resident 3 but it was almost shift change and asked if Resident 3 would rather have the next shift change him/her. Resident 3 stated s/he would wait. On 09/13/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on 08/27/2023 with a primary diagnosis of multiple sclerosis. His/her ISP, updated 08/01/2024, indicated s/he required assistance with bathing on Tuesdays and Fridays and dressing/undressing in the morning and evening daily. Resident 3's ISP read, "...physically assist resident to use toilet, and/or change adult undergarments and provide pericare [sic] as needed. May require transfer assistance.. [sic] Community to provide assistance to ensure and maintain independence where possible, dignity and hygiene." Resident 3's September TAR had more blanks than documented administrated tasks. According to this record, Resident 3 was not toileted or changed on the PM shift on 09/09/2024, and had not received a shower any day in September. S/He received morning dressing assistance 4 times, and evening dressing assistance 4 times.	{M 438}		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist.	M 458		

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M 458	Continued From page 29	M 458		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure prescription medications were securely stored.

Findings include:

On 07/29/2024, the Department received a complaint related to the provider's medication storage.

On 09/11/2024 at 10:11 AM, Surveyor observed the provider's medication room door to be ajar. Surveyor opened the door and found no staff in the room. The medication cart inside the room was unlocked and the top drawer was open. Surveyor had full access to the medications in the cart.

At 11:06 AM, Surveyor interviewed Caregiver J. Caregiver J stated s/he was the medication passer today. Caregiver J stated s/he normally worked alone but today House Manager (HM) D was onsite because Caregiver J had a family emergency that required him/her to leave at 8:00 AM. Caregiver J stated HM D came in to cover the shift, and Caregiver J left the medication room door and cart open because s/he did not know if HM D had the code or key to access the medications.

At 12:29 PM, Surveyor observed the medication room door to be shut but unlocked. Surveyor

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M 458	Continued From page 30 opened the medication room and found the medication cart to be locked. Surveyor left the medication room, shutting the door behind him/her. At approximately 12:30 PM, Surveyor asked Caregiver J to show Surveyor the medication area. Caregiver J entered the medication room through the unlocked door and opened the medication cart with a key that was hanging on the corkboard in the medication room. Caregiver J opened the medication cart and returned the key to the corkboard. At 12:56 PM, Surveyor interviewed Executive Director (ED) A, House Manger (HM) D, and Manager C. Manager C stated caregivers were expected to keep the medication room always locked. Manager C stated the key to the medication cart should not be available to undesignated people. HM D stated s/he had access to the medication room and cart, so it was not necessary for Caregiver J to leave the medications unsecured.	M 458		
{M 464}	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file.	{M 464}		

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{M 464}	Continued From page 31 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 3 had a written order from his/her prescribing physician, specifying who by name or position was permitted to administer the medication, under what circumstances, and in what dosage the medication was to be administered. This is a repeat deficiency. See Statement of Deficiency (SOD) E3GH11, dated 05/18/2022, and E3GH12, dated 06/27/2023. Findings include: On 09/11/2024 at 9:49 AM, Surveyor interviewed Resident 3. Resident 3 stated staff managed and administered his/her medications. On 09/12/2024, Surveyor reviewed resident records. Resident 3 was admitted on 08/27/2023. Resident 3's record did not include a written authorization for the provider to administer Resident 3's medications. On 09/12/2024 at 5:07 PM, Surveyor sent Executive Director (ED) A, Director of Marketing (DM) B, and Manager C an email requesting the written authorization to administer Resident 3's medications. Surveyor asked that the provider indicate in their reply if they do not have the requested record so Surveyor would know not to wait for it. As of 09/13/2024, Surveyor did not receive the requested record or a response from the provider indicating they did not have the record.	{M 464}		

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M 482	88.09(1)(a) RESIDENT RECORDS The licensee shall maintain a record for each resident. Resident records shall be maintained in a secure location within the home to prevent unauthorized access. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure resident records were stored in a secure location. Findings include: On 07/29/2024, the Department received a complaint related to resident record storage. On 09/11/2024 at approximately 10:20 AM, Surveyor observed a stack of papers on a table in the provider's basement lounge area. The only employee on the premises at the time of the observation was upstairs. The lounge area was accessible to anyone with the ability to navigate stairs. The stack of papers included resident medical records, hospice notes, and guardianship paperwork. The records were not safeguarded from unauthorized use. At 12:56 PM, Surveyor interviewed Executive Director (ED) A, House Manger (HM) D, and Manager C. ED A stated all paper records should be stored in the locked medication room.	M 482		
Z 012	50.065(2)(bm) OUT OF STATE BACKGROUND CHECKS	Z 012		

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Z 012	Continued From page 33 If the person who is the subject of the search under par. (am) or (b) is not a resident of this state or if at any time within the 3 years preceding the date of the search that person has not been a resident of this state, or if the department or entity determines that the person's employment, licensing, or state court records provide a reasonable basis for further investigation, the department or the entity shall make a good faith effort to obtain from any state or other United States jurisdiction in which the person is a resident or was a resident within the 3 years preceding the date of the search information that is equivalent to the information specified in par. (am) 1. or (b) 1. The department or entity may require the person to be fingerprinted on 2 fingerprint cards, each bearing a complete set of the person's fingerprints. The department of justice may provide for the submission of the fingerprint cards to the federal bureau of investigation for the purposes of verifying the identity of the person fingerprinted and obtaining the records of his or her criminal arrests and convictions. This Rule is not met as evidenced by: Based on record review and interview, the provider did not make a good-faith effort to obtain a criminal history report from all states in which Caregiver F lived within the 3 years preceding his/her caregiver background check. Findings include: On 09/11/2024 and 09/12/2024, Surveyor reviewed employee records. Caregiver F was	Z 012		

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Z 012	Continued From page 34 hired on 02/12/2024. Caregiver F completed a background information disclosure (BID) form on 02/06/2024. According to this BID form, Caregiver F lived in Pennsylvania within 3 years of 02/06/2024. Caregiver F's record did not include evidence of the provider's attempt to obtain a criminal history report from Pennsylvania. On 09/12/2024 at 10:22 AM, Surveyor sent Executive Director (ED) A and Director of Marketing (DM) B an email indicating staff records were not complete. Surveyor asked if the provider had any additional records for Caregiver F for review. The provider did not answer the question, but provided additional documents for review in their reply. The additional documents did not include evidence of their attempt to obtain a Pennsylvania criminal history report.	Z 012		