STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017702	A. BUILDING: _____ B. WING _____	R-C 06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF MADISON OAKWOOD	5555 BURKE RD MADISON, WI 53718

(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 06/10/2024 to 06/11/2024, Surveyors conducted a verification visit and complaint investigation at Cottages of Madison Oakwood, a CBRF in Madison. Twelve deficiencies were identified. Twelve deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) EC0P11, dated 03/23/2021, EC0P12, dated 06/15/2021, EC0P13, dated 10/05/2021, GT2Y11, dated 10/13/2021, EC0P14, dated 03/29/2022, EC0P15, dated 07/13/2022, EC0P16, dated 10/07/2022, M20M11, dated 07/11/2023, M20M12, dated 11/02/2023 and EC0P19, dated 02/21/2024. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 16	{N 000}		
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 record review and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. This is a repeat deficiency. See Statement of Deficiency (SOD) GT2Y11, dated 10/13/2021,	N 196		

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

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N 196	Continued From page 1 EC0P16, dated 10/07/2022, M20M11, dated 07/11/2023 and M20M12, dated 11/02/2023. Findings include: From 06/10/2024 to 06/11/2024, Surveyor conducted 2 verification visits and 1 complaint investigation at the provider's facility. As a result of the survey, 12 deficiencies were identified, all of which were repeat deficiencies. Deficiencies included the following: - Resident Health Screenings: The provider did not have clinically apparent communicable disease screens, including tuberculosis tests, in the records of 4 of 6 residents reviewed. - Assessments: The provider did not ensure assessments were completed following falls. - Qualified Staff: The provider did not ensure there was at least 1 qualified care staff present at all times. The provider had a Caregiver GG, who was not fully trained, work the overnight shift without a fully trained caregiver working with Caregiver GG the entire shift. - Documentation of Medication Administration: The provider did not ensure the need and response for PRN medications were documented for 2 of 2 residents reviewed. - Personal Cares: The provider did not ensure Resident 15 received assistance with incontinence cares and Resident 5 received assistance with grooming tasks. - Leisure Time Activities: The provider did not ensure daily programing that met the interests of residents was provided. - Health Monitoring: The provider did not ensure vitals and blood sugars were monitored and recorded as ordered. The provider did not clarify diabetic management orders with Resident 17's physician when unsure of the orders.	N 196		

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N 196	Continued From page 2 - Nutrition: The provider did not ensure a weekly menu was prepared and posted for residents. - Toilet and Bathing Areas: The provider did not ensure bathrooms were clean and in good repair. - Interior Floors, Walls, Ceilings: The provider did not ensure floors and walls were clean and in good repair. - Toxic Substances: The provider did not ensure all toxic chemicals were secured and not accessible to residents. On 06/10/2024 at approximately 3:15 p.m., Surveyor reviewed the above concerns with Executive Regional Director V. Regional Executive Director V wrote down Surveyor's concerns. Regional Executive Director V acknowledged the facility "had work to do." Regional Executive Director V stated s/he was usually at the facility 1 day/week. Regional Executive Director V voiced frustration that s/he did a lot of training on how to correct concerns, but then things weren't followed through on and caregiver turnover was frequent. Cross Reference: N0302 83.28(4)(a) Resident Health Screening And Documentation N0381 83.35(1)(a) Pre-Admission And Ongoing Assessments N0397 83.36(1)(b)2. Qualified Staff In Charge, On Duty And Awake N0415 83.37(2)(d) Documentation of Medication Administration N0425 83.38(1)(a) Personal Cares N0427 83.38(1)(c) Leisure Time Activities N0431 83.38(1)(g) Health Monitoring N0450 83.41(2)(c) Nutrition: Menus N0490 83.44(2)(b) Toilet And Bathing Area N0491 83.44(2)(c) Interior Floors, Walls And Ceilings	N 196		

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N 196	Continued From page 3 N0499 83.45(3) Toxic Substances	N 196		
{N 302}	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 6 residents reviewed were screened for clinically apparent communicable disease, including tuberculosis, within 90 days before or 7 days after admission and that documentation of the screening was maintained in each resident's record. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P19, dated 02/21/2024. Findings include: On 06/10/2024 at approximately 9:15 a.m., Surveyor requested communicable disease	{N 302}		

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{N 302}	Continued From page 4 screenings, including tuberculosis tests, for 6 residents admitted after Surveyor's last visit to the facility from AM Shift Lead AA and Regional Executive Director V. On 06/10/2024 at approximately 10:00 a.m., Regional Executive Director V provided Surveyor with tuberculosis tests for 2 of 6 residents requested. Regional Executive Director V stated s/he was unable to locate tuberculosis tests for Resident 14, Resident 15, Resident 16 or Resident 17 in the resident records, but that s/he was going to dig through the office of Administrator CC. On 06/10/2024 at approximately 10:55 a.m., Regional Executive Director V stated, "I'm waving my white flag. I've dug through piles and can't locate [communicable disease screenings]." Regional Executive Director V was unable to provide documentation of a communicable disease screen, including a tuberculosis test, for the following residents: - Resident 14, who admitted on 05/17/2024. - Resident 15, who admitted on 05/17/2024. - Resident 16, who admitted on 05/24/2024. - Resident 17, who admitted on 05/14/2024.	{N 302}		
{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	{N 381}		

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{N 381}	Continued From page 5 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 an assessment was completed when there was a change in 1 of 2 residents reviewed. The provider did not complete a fall assessment when Resident 13 sustained 4 falls from 05/10/2024 to 06/10/2024. This is a repeat deficiency. See Statement of Deficiency (SOD) M20M11, dated 07/11/2023 and EC0P19, dated 02/21/2024. Findings include: On 06/10/2024 at approximately 10:30 a.m., Surveyor reviewed Resident 13's record. Resident 13 was admitted to the provider's facility on 08/31/2023. Resident 13's record, dated 05/10/2024 to 06/10/2024, included the following incident reports: - 05/11/2024: Resident rolled out of bed. *No vitals taken. Pain rated at a 5. PCP not updated. No intervention for fall prevention documented. - 05/29/2024: Resident tried using the bathroom and hit his/her head. Resident 13 was dizzy and in pain. "Emergency" was called, checked him/her out and determined s/he was okay to stay at facility. *Physician not notified. - 05/29/2024: Resident fell while getting out of bed and hit his/her head, causing a bruise. *Sent to ER. No intervention listed. - 06/08/2024: Found in bathroom sitting against	{N 381}		

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{N 381}	Continued From page 6 the wall. *No vitals taken. Pain rated at a 4. PCP and family not notified. Surveyor reviewed Resident 13's most recent assessment, dated 06/07/2024, which created the individual service plan (ISP). The assessment identified Resident 13 as a fall risk and stated Resident 13 must be encouraged to use walker. The ISP also indicated Resident 13 required a mechanical lift for transfers and was unable to ambulate. Surveyor then observed Resident 13 used a wheelchair to mobilize. On 06/10/2024 at approximately 1:15 p.m., Surveyor reviewed Resident 13's record with Regional Executive Director V. Surveyor asked what the procedure was following a fall. Regional Executive Director V stated an assessment, including pain and vitals assessment, should be completed and the resident should be put on "follow up" protocol in the electronic charting program to monitor over the next 3 days. Regional Executive Director V checked Resident 13's electronic record and stated the "follow up" was not completed after the falls that occurred 05/10/2024 - 06/10/2024. Surveyor asked if a fall assessment was completed to identify fall prevention interventions. Regional Executive Director V reviewed Resident 13's record and replied, "No." Resident 13 sustained 4 falls from 05/10/2024 to 06/10/2024. For 2 of 4 falls, a thorough assessment of Resident 13's condition was not completed status post fall. For 4 of 4 falls, an assessment was not completed to determine fall prevention interventions.	{N 381}		

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{N 397}	Continued From page 7	{N 397}		
{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 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 1 qualified care staff was present in the CBRF when 1 or more residents were present in the CBRF. Caregiver GG worked an overnight shift by him/herself without all trainings completed. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P19, dated 02/21/2024. Findings include:	{N 397}		

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{N 397}	Continued From page 8 On 06/10/2024 at approximately 10:00 a.m., Surveyor reviewed the provider's staff schedule, dated 05/10/2024 to 06/10/2024. The schedule indicated Caregiver GG worked the overnight shift (11:00 p.m. to 7:00 a.m.) by him/herself on 05/11/2024. On 06/10/2024 at approximately 10:15 a.m., Surveyor reviewed Caregiver GG's completed trainings on the Community-Based Care and Treatment Training Registry. The registry indicated Caregiver GG had not completed training in First Aid. Surveyor asked Regional Executive Director V if Caregiver GG had completed training that wasn't on the registry or met an exemption. On 06/10/2024 at approximately 2:00 p.m., Regional Executive Director V stated s/he didn't have documentation of trainings or an exemption but that Caregiver GG was scheduled to take the First Aid class with Regional Executive Director V later in the month. Surveyor shared concern that Caregiver GG worked 05/11/2024 overnight by him/herself without being full trained. Regional Executive Director V closed his/her eyes and took a deep breath.	{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	N 415		

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N 415	Continued From page 9	N 415		

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 the need and response for a PRN medication was documented for 2 of 2 residents reviewed. The need and response were not documented for each of Resident 16's administrations of Lorazepam and Melatonin. The need and response was not documented for each of Resident 15's administrations of Oxycodone.

This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P11, dated 03/23/2021 and M20M12, dated 11/02/2023.

Findings include:

On 06/10/2024 at approximately 10:30 a.m., Surveyor reviewed resident records and identified the following concerns:

Example 1 - Resident 16:

Resident 16 was admitted to the provider's facility on 05/24/2024. Resident 16's physician orders included the following:

- Lorazepam .5 mg (Start Date: 05/29/2024) - Take every 4 hours as needed for anxiety.
- Melatonin 3 mg (Start Date: 05/24/2024) - Take 1 tablet as needed at bedtime.

Resident 16's Medication Administration Record (MAR), dated 05/24/2024 to 05/31/2024,

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N 415	Continued From page 10 documented Resident 16's Lorazepam was administered 5 times. One of 5 administrations of Lorazepam did not include the response to the Lorazepam. Resident 16's MAR documented Resident 16's Melatonin was administered 5 times. Five of 5 administrations of Melatonin did not include documentation of the need or response. Administrations that did not document need and/or response occurred on 05/26/2024, 05/27/2024, 05/28/2024 x3 and 05/31/2024. Example 2 - Resident 15: Resident 15 was admitted to the provider's facility on 05/17/2024. Resident 15's physician orders included an order for Oxycodone 5-325 mg (Start Date: 05/28/2024). Resident 15's MAR, dated 05/17/2024 to 05/31/2024, documented 2 occurrences of Oxycodone PRN being administered. One of 2 administrations did not document the response to the Oxycodone. Administration that did not document the response occurred on 05/28/2024. On 06/10/2024 at approximately 1:15 p.m., Surveyor reviewed Resident 16 and Resident 15's MARs with Regional Executive Director V. Regional Executive Director V reviewed Resident 16 and Resident 15's electronic record and confirmed documentation of the need and response for PRN medications was missing in the records. Regional Executive Director V stated s/he had completed trainings with staff and had intended to complete another training on 06/10/2024.	N 415		
N 425	83.38(1)(a) Personal care.	N 425		

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N 425	Continued From page 11 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: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure personal care services were provided to meet the needs of residents. Resident 15 did not receive immediate assistance with his/her incontinence. Resident 5 did not receive assistance with his/her grooming tasks. This is a repeat deficiency. See Statement of Deficiency (SOD) M20M12, dated 11/02/2023. Findings include: On 06/10/2024, Surveyor conducted a verification visit. Surveyor observed the following concerns with personal cares: Example 1 - Resident 15: On 06/10/2024 at approximately 2:00 p.m., Surveyor observed Resident 15 in his/her bed	N 425		

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with his/her lower body uncovered from the hallway. Surveyor could see and smell Resident 15 had been incontinent of bowel. Surveyor asked Resident 15 if s/he needed assistance. Resident 15 stated s/he had called for help and a caregiver said s/he would be coming right back. Resident 15 was not sure how long ago s/he had called for assistance. Surveyor then went to the common area of the facility and observed 2 of 2 caregivers on shift (Caregiver FF and Caregiver II) were both outside. Caregiver FF was sitting in a chair on the front porch. Caregiver II was standing near Caregiver FF smoking. Regional Executive Director V was the only staff member present inside the building.

On 06/10/2024 at approximately 2:10 p.m., Surveyor informed Regional Executive Director V that Resident 15 was waiting for personal care assistance and both caregivers were currently outside the facility. Regional Executive Director V looked outside and saw both caregivers in front of the building. Regional Executive Director V then went outside and instructed the caregivers to assist Resident 15. When caregivers came inside, Surveyor asked how they would know a resident was calling for assistance if they were both outside. Caregiver FF replied that s/he already knew Resident 15 needed assistance before s/he went outside. Caregiver FF stated s/he told Resident 15 s/he would come back with Caregiver II to provide assistance.

On 06/10/2024 at approximately 2:15 p.m., Regional Executive Director V and Surveyor reviewed Resident 15's individual service plan (ISP), dated 05/23/2024, which indicated Resident 15 required assistance of 1 for toileting needs, indicating Caregiver FF could have completed Resident 15's cares without the

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assistance of Caregiver II.

On 06/10/2024, Resident 15 was incontinent of bowel and was left in his/her incontinence while Caregiver FF and Caregiver II went out to the facility's front porch. Resident 15 was not tended to by caregivers until instructed to do so by Regional Executive Director V.

Example 2 - Resident 5:

On 06/10/2024 at approximately 1:45 p.m., Surveyor observed Resident 5 with facial hair (mustache and goatee). Surveyor asked Resident 5 if s/he preferred to have his/her facial hair grown out. Resident 5 responded, "I'll take it off." Surveyor asked if caregivers offered to assist Resident 5 with grooming tasks. Resident 5 didn't answer yes/no, but stated, "I'll do it myself."

On 06/10/2024 at approximately 2:00 p.m., Surveyor interviewed Caregiver FF. Surveyor asked Caregiver FF if Resident 5 preferred to have facial hair. Caregiver FF stated s/he was unsure. Surveyor asked Caregiver FF if the facility had a razor and if caregivers offered to assist residents with grooming tasks. Caregiver FF did not confirm whether or not the facility had a razor or if caregivers assisted with grooming tasks.

On 06/10/2024 at approximately 2:30 p.m., Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider's facility on 03/15/2019. Resident 5's ISP, dated 08/30/2023, stated "Resident requires staff monitoring and/or reminders and cues to complete grooming tasks. Staff are to ensure they are setting up [his/her] grooming supplies and encouraging resident and assisting resident complete tasks. Staff to

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N 425	Continued From page 14 physically assist resident." On 06/10/2024 at approximately 3:15 p.m., Surveyor interviewed Regional Executive Director V. Surveyor shared observation that Resident 5 had grown out facial hair. Executive Director V replied, "Yes, I noticed that. I ordered a razor for the facility right away." Regional Executive Director V stated it would be an expectation for caregivers to assist with grooming tasks, including shaving.	N 425		
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, interview and record review, the provider did not ensure a daily activity program that met the interests and capabilities of residents was provided. Findings include:	N 427		

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N 427	Continued From page 15 On 06/10/2024 at approximately 8:00 a.m., Surveyor toured the provider's facility. Surveyor observed an activity schedule that listed the following for 06/10/2024: 9:00 a.m. Exercise 10:00 a.m. Baking Club 1:00 p.m. Wreath Making 3:00 p.m. Manicures 6:00 p.m. Relax/Reflect On 06/10/2024 at approximately 8:30 a.m., Surveyor observed residents served breakfast. After breakfast, residents went back to their rooms or to the living room area. On 06/10/2024 from 9:00 a.m. to 11:30 a.m., Surveyor did not observe residents offered an activity or engaged in an activity. Surveyor observed 4 residents sitting in the living room area watching television, which was on mute. On 06/10/2024 at approximately 11:25 a.m., Surveyor interviewed Resident 17. Surveyor reviewed the facility's activity calendar with Resident 17. Resident 17 stated s/he wasn't familiar with the activity calendar and had not observed activities take place. Resident 17 stated no one mentioned exercise or baking club to him/her earlier in the morning. On 06/10/2024 at approximately 12:15 p.m., Surveyor interviewed Caregiver FF. Surveyor asked Caregiver FF about the facility's activity programming. Caregiver FF stated the provider was currently looking to hire new activity personnel so the activity calendar was not followed. Caregiver FF stated programming had not taken place for approximately 2 weeks, but s/he tried to encourage the residents to talk and	N 427		

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N 427	Continued From page 16 visit with Caregiver FF instead.	N 427		
{N 431}	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.	{N 431}		

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{N 431}	Continued From page 17 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 residents reviewed had their health monitored. The provider did not follow or clarify Resident 17's order for blood sugar (BS) checks. The provider did not ensure Resident 13's blood pressure and pulse were monitored and documented as ordered. The provider did not ensure Resident 11's blood sugar was monitored and documented as ordered. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P16, dated 10/07/2022, EC0P17, dated 04/06/2023, EC0P18, dated 09/11/2023 and EC0P19, dated 02/21/2024. Findings include: On 06/10/2024 at approximately 10:30 a.m., Surveyor reviewed resident records and identified the following concerns: Example 1 - Resident 17: Resident 17 was admitted to the provider's facility on 05/14/2024 with a diagnosis of diabetes. Resident 17's physician orders, dated 05/07/2024, included an order to test Resident 17's BS 4 times daily. Resident 17's Medication Administration Record (MAR), dated 05/14/2024 to 06/06/2024, included 9 total BS readings. On 06/10/2024 at approximately 12:20 p.m., Surveyor asked Regional Nurse HH to clarify Resident 17's orders. Regional Nurse HH reviewed Resident 17's orders and confirmed Resident 17's BS should be checked 4 times daily based on his/her order. Surveyor shared observation that Resident 17's BS was checked and documented 9 times from 05/14/2024 to	{N 431}		

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{N 431}	Continued From page 18 06/06/2024. Regional Nurse HH stated s/he was unsure why Resident 17's BS was ordered to be checked 4 times daily when Resident 17 didn't receive insulin 4 times daily. On 06/10/2024 at approximately 1:00 p.m., Regional Executive Director V provided Surveyor with a note that stated Administrator CC had requested clarification regarding the BS orders. The note did not identify when the request for clarification was made, who the request was made to or how the request was made. Resident 17 was admitted to the provider's facility on 05/14/2024. As of 06/10/2024, the provider had not followed or clarified Resident 17's order to check his/her BS 4 times daily. Example 2 - Resident 13: Resident 13 was admitted to the provider's facility on 08/31/2023 with diagnosis of atrial fibrillation. Resident 13's physician orders included Diltiazem 120 mg (Start Date: 05/03/2024) - Take 1 tablet daily - Hold for heart rate less than 60 or blood pressure (BP) with systolic less than 100. Resident 13's record, dated 05/10/2024 to 05/31/2024, indicated the following: - Neither BP, nor pulse were documented on 05/10/2024 - 05/12/2024, 05/17/2024 - 05/19/2024, 05/22/2024 - 05/27/2024 and 05/29/2024 - 05/31/2024. - Only pulse was documented (No BP) on 05/15/2024 - 05/16/2024, 05/20/2024 and 05/28/2024. On 06/10/2024 at approximately 3:15 p.m., Surveyor reviewed concern with Regional Executive Director V that Resident 13's record did	{N 431}		

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{N 431}	Continued From page 19 not include a BP and pulse for each date reviewed. Regional Executive Director V wrote down Surveyor's concern. Regional Executive Director V stated the provider was scheduled to complete additional training with staff that day. Example 3 - Resident 11: Resident 11 was admitted to the provider's facility on 12/01/2022 with a diagnosis of diabetes. Resident 11's physician orders included an order to check BS 2 times every other day right before meal and 2 hours after meal (Start Date: 03/26/2024). Resident 11's MAR, dated 05/10/2024 to 06/06/2024, indicated Resident 11's BS was checked on odd days in May 2024 and even days in June 2024. The MAR indicated the following concerns: - BS was not checked at all on 05/17/2024, 05/19/2024 and 05/25/2024. - BS was only checked 1 time on 05/21/2024, 05/23/2024, 05/29/2024 and 06/02/2024. On 06/10/2024 at approximately 3:15 p.m., Surveyor reviewed concern with Regional Executive Director V that Resident 11's record did not include BS readings for every date reviewed. Regional Executive Director V wrote down Surveyor's concern. Regional Executive Director V stated the provider was scheduled to complete additional training with staff that day.	{N 431}		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly	N 450		

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N 450	Continued From page 20 written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a weekly menu was prepared and available to residents. This is a repeat deficiency. See Statement of Deficiency (SOD) M20M11, dated 07/11/2023 and and M20M12, dated 11/02/2023. Findings include: On 06/10/2024 at approximately 7:55 a.m., Surveyor observed 6 residents sitting at the dining room table waiting for breakfast. Surveyor walked around the dining room and was unable to locate a menu indicating what would be served for breakfast. Surveyor asked the residents what would be served for breakfast. Resident 12 stated, "We don't know." Surveyor asked Caregiver FF if s/he knew what would be served for breakfast. Caregiver FF stated s/he wouldn't know until the food was ready to be served. Caregiver FF stated s/he didn't know what would be served for breakfast or lunch that day. On 06/10/2024 at approximately 8:25 a.m., Surveyor observed residents served eggs, toast, sausage and strawberries. On 06/10/2024 at 8:30 a.m., Surveyor interviewed Cook EE. Cook EE stated s/he did not have a menu to follow. Cook EE stated the administrator typically created a weekly menu that began on Sunday but Cook EE did not have one to follow for 06/09/2024 or 06/10/2024. Cook EE stated	N 450		

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N 450	Continued From page 21	N 450		

s/he was just making meals based on the food s/he had available to him/her that day.

On 06/10/2024 at approximately 9:15 a.m., Surveyor requested a copy of the June 2024 menu from AM Shift Lead AA and Regional Executive Director V.

On 06/10/2024 at approximately 10:00 a.m., AM Shift Lead AA provided Surveyor with a menu for May 2024.

On 06/10/2024 at approximately 10:30 a.m., Regional Executive Director V provided Surveyor with a 3 week menu that had no dates. Executive Regional Director V stated the 3 week rotating menu was all s/he was able to locate for a June menu. Executive Regional Director V confirmed the menus did not include dates and did not match what had been served for breakfast.

On 06/10/2024 at approximately 11:15 a.m., Surveyor observed Cook EE bring lunch to the facility's kitchenette. Lunch included 2 key lime pies, which Cook EE put in the refrigerator.

On 06/10/2024 at approximately 11:53 a.m., Surveyor observed the last resident be served lunch. Surveyor observed none of the residents had received a beverage. After a resident called out for a drink, Caregiver FF provided residents with orange juice and/or water.

On 06/10/2024 at approximately 12:00 p.m., Surveyor observed residents begin leaving the table. Surveyor observed that dessert had not been served.

On 06/10/2024 at approximately 12:10 p.m., Surveyor asked Caregiver FF if residents were

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N 450	Continued From page 22 going to be served dessert. Caregiver FF stated s/he wasn't sure if there was dessert. Caregiver FF stated residents usually got dessert, but s/he wasn't sure if there was any for that day. Surveyor shared that s/he observed Cook EE put 2 key lime pies in the fridge. Caregiver FF looked in the refrigerator and said s/he would need to confirm with Cook EE that the pie was for lunch. On 06/10/2024 at approximately 12:17 p.m., Caregiver FF stated s/he confirmed the pie was to be served with lunch and began serving the pie. At that time only 3 residents were left at the dining room table. All other residents were served pie in common areas or their rooms. The provider did not have a menu created and posted for residents to know what would be served or for staff to know what to serve.	N 450		
N 490	83.44(2)(b) Toilet and bathing area. All toilet and bathing areas, facilities and fixtures shall be clean and in good working order. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that toilet and bathing areas for two resident bathrooms were clean and in good working order which effected 16 of 16 residents at the facility. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P19, dated 02/21/2024. Findings include: On 06/10/2024 at approximately 8:00 a.m., Surveyor toured the provider's facility and	N 490		

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N 490	Continued From page 23 observed the following: - Public bathroom 1, located on the east side of building and used by all residents, had a broken toilet paper holder and broken toilet seat (Photo 5 and Photo 7). The toilet seat was a safety concern as it would easily slide from one side to the other with any movement. Three toothbrushes were on the vanity, not labeled and open to air (Photo 6). The tub had gray and brown water markings around the drain (Photo 8). - Public bathroom 2, located on the west side of the building and used by all residents, had fecal matter splattered on the inside of the toilet. On 06/10/2024 at approximately 2:00 p.m., Surveyor toured the provider's facility to follow up on cleanliness concerns. Surveyor observed the following: - Public bathroom 1 remained in the condition Surveyor had observed the bathroom in approximately 6 hours earlier; however, the toilet now had fecal matter on the toilet seat. - Public bathroom 2 had the same fecal matter splattered on the inside of the toilet that Surveyor had observed approximately 6 hours earlier and now had fecal matter on the toilet seat. On 06/10/2024 at approximately 3:15 p.m., Surveyor reviewed concern regarding the bathrooms uncleanliness and damaged items with Regional Executive Director V. Regional Executive Director V made note of the damaged items. Regional Executive Director V stated caregivers should have addressed cleanliness concerns.	N 490		

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{N 491}	Continued From page 24	{N 491}		
{N 491}	83.44(2)(c) Interior floors, walls and ceilings. Every interior floor, wall and ceiling shall be clean and in good repair. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all interior floors and walls were clean and in good repair. The providers walls had scrapes and stains. The provider's floor had debris and dust build up throughout the facility. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P19, dated 02/21/2024. Findings include: On 06/10/2024 at approximately 8:00 a.m., Surveyor toured the provider's facility and observed the following concerns throughout the facility: - Door frames and trim throughout the facility had wood scraped off and damaged seals (Photo 2, Photo 3, Photo 4). - Drywall had scrapes. - The shower room floor had gray markings on the floor (Photo 1). The markings were dry to touch. On 06/10/2024 at approximately 3:15 p.m., Surveyor reviewed concern with Regional Executive Director V that the facility's door frames, trim and drywall were not in good repair and the shower room was not in a clean condition. Regional Executive Director V wrote down Surveyor's concerns and had no questions or comments for Surveyor.	{N 491}		

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N 499	Continued From page 25	N 499		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure toxic chemicals were stored in a secured area. Cleaning agents were accessible to residents. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P12, dated 06/15/2021, EC0P13, dated 10/05/2021, EC0P14, dated 03/29/2022, M20M11, dated 07/11/2023 and M20M12, dated 11/02/2023. Findings include: On 06/10/2024 at approximately 8:00 a.m., Surveyor toured the provider's facility. Surveyor observed the provider's laundry room was unlocked. Inside the laundry room Surveyor observed a container of "Dishwasher Pacs" with a label that stated "Harmful if swallowed or put in mouth" and "All Mighty Pacs" for laundry with a label that stated "Harmful if put in mouth or swallowed. Eye irritant." Caregiver FF was in the hallway while Surveyor made observation. Surveyor asked Caregiver FF if the laundry room was typically kept locked. Caregiver FF replied, "Yeah, but not when I'm here and working. It's easier to get in this way." Surveyor then toured the remainder of the facility and observed the storage closet with a sign that	N 499		

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N 499	Continued From page 26 stated "This door needs to be locked at all times. Only staff in the room" on it. The door was unlocked. Surveyor observed Lysol All Purpose Cleaner, Lysol Fresh Cling Gel, Lysol Glass Cleaner and All Mighty Pacs in the closet and accessible to residents.	N 499		