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{N 000}	Initial Comments A verification visit for SOD (Statement of Deficiencies) F9O311 and an investigation into 8 complaints was conducted at Wellington Place at Biron on 06/13/2023 with information gathered through 06/20/2023. As a result of this survey 5 of the previous 9 deficiencies were corrected with 4 of them being repeat violations. Four of the complaints were unsubstantiated and 4 were substantiated. A total of six deficiencies were identified. Per state statutes a $200.00 re-visit fee is assessed. Census: 26	{N 000}		
{N 161}	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not ensure injuries of unknown origin were investigated to rule out potential misconduct or to identify potential care plan interventions to prevent future injuries for 1 (Resident 1) of 3 residents reviewed. Resident 1 was found to have a bruise to the left chest area. The provider did not investigate Resident 1's IUO (injury of unknown origin) in an	{N 161}		

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

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attempt to ensure misconduct had not occurred or to determine the root cause for possible ISP (Individual Service Plan) revisions.

This is a repeat deficiency. See Statement of Deficiency (SOD) F90311, dated 10/12/2022.

Findings include:

The facility's policy regarding reporting and investigating allegations of caregiver misconduct, dated 03/28/2012, stated, "The facility will thoroughly investigate all reported cases of alleged violations to the Department of Health Services within the required timeframes...To ensure that all alleged abuse, neglect, mistreatment, and injuries of unknown source are investigated in an unbiased and complete and thorough manner consistent with federal and state regulations...All IUO's...must be reported to the administrator or designee immediately. A complete body assessment, if applicable, shall be conducted to determine the extent of any injuries. The findings shall be documented in the medical record...The staff member identifying the injury shall complete an incident report. The administrator or designee shall obtain initial statements from the resident and individual identifying the injury. The administrator or designee shall review the appropriate chart documentation, 24-hour report, etc. which may/could potentially explain the cause of injury. If after obtaining the initial statement from the resident and/or individual identifying the injury, the injury is deemed to be explainable, the documentation including statements and relevant/pertinent information is filed with the incident report the investigation is considered complete. If after obtaining the initial statement from the resident and/or individual identifying the

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{N 161}	Continued From page 2	{N 161}		

injury, the origin of the injury remains unknown and no reasonable explanation can be identified, a complete and thorough investigation must be initiated..."

On 06/13/2023, Surveyor reviewed the closed medical record of Resident 1. The face sheet indicated Resident 1 had a legal guardian and was admitted with diagnoses to include hypertension, diabetes, and muscle weakness. Resident 1's current ISP, last reviewed/revised on 03/22/2022, documented the resident required assistance from one staff for transfers and ADLs (Activities of Daily Living). Additionally, the ISP indicated Resident 1 was able to communicate without issues.

An ED (Emergency Department) report dated 05/07/2023, indicated Resident 1 presented to the ED at 11:58 PM for altered mental status and was admitted to the hospital for further evaluation. Resident 1's hospital discharge summary indicated the resident was discharged to a skilled nursing facility on 05/15/2023 with multiple diagnoses to include "Contusion of left [Chest] likely from trauma..." The ED to hospital admission report included images of Resident 1's bruise to her/his left [chest] and indicated the bruise was "present on original admission." Surveyor noted the images of the bruise to Resident 1's left chest appeared maroon/purple in color and covered the left chest area, extending down to the left armpit region.

Resident 1's closed medical record did not include any documentation regarding a bruise to the left chest area.

On 06/13/2023 at 11:30 AM, Surveyor interviewed RA (Resident Assistant)-C. RA-C confirmed

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Resident 1 had a bruise to the left chest area which was observed sometime around the end of April 2023. RA-C described Resident 1's bruise to the chest area as a "large bluish/purplish oval shape" that extended from the middle of Resident 1's chest area to the resident's armpit. Surveyor asked RA-C what Resident 1 explained to RA-C as the source of the bruise to her/his left chest. RA-C stated, "When I asked [Resident 1], [s/he] didn't say anything. [RA-D] was in the room at the time when I saw the bruise and [RA-D] was surprised to see the bruise...[RA-D] and I were like how did [s/he] get the bruise...I don't know how the bruise happened or how it could have happened." Surveyor then asked RA-C if s/he documented the bruise or completed an incident report. RA-C stated, "I'm supposed to document, but I didn't because I had a lot going on at the time."

On 06/13/2023 at 2:30 PM, Surveyor interviewed RA-D. RA-D confirmed Resident 1 had a bruise to the left chest area which was observed "a week or so" prior to Resident 1's 05/07/2023 hospital admission. RA-D stated, "[RA-C] observed the bruise first and then I saw the bruise to [Resident 1's] chest area. I don't know how [Resident 1] got the bruise. We asked [Resident 1] multiple times but [s/he] did not answer." Surveyor questioned RA-D if s/he documented the bruise or reported the bruise to anyone. RA-D stated, "I didn't chart anything about [Resident 1's] bruise, and I didn't report it to anyone."

On 06/14/2023 at 12:45 PM, Surveyor interviewed Director of Operations A regarding the IOU noted on Resident 1's left chest area. Director of Operations A indicated not knowing anything regarding Resident 1's bruise to his/her

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{N 161}	Continued From page 4 left chest area. Director of Operations A stated, "I would have expected staff to report it and documented the bruise, so we could investigate and find out the root cause and explanation for the bruise...But we can't do that if we don't know about it." Director of Operations A verified the facility did not conduct an investigation into Resident 1's IUO.	{N 161}		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on interview and record review, the provider did not immediately notify a resident's physician and legal representative when there was a significant change in the resident's physical or mental condition for 1 of 1 resident. Resident 1 experienced a physical and mental change in condition including a decline in mood, a decrease in appetite, difficulty bearing weight and an increased need for assistance with transfers. The provider did not immediately notify Resident 1's legal representative or physician regarding these changes for potential interventions. Findings include:	N 169		

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The facility's policy regarding recognizing and responding to a resident change in condition, dated 04/27/2012, stated, "The facility believes that a primary goal of identifying an acute change of condition is to enable staff to evaluate and manage a patient at the facility and avoid transfer to a hospital or ED (Emergency Department). To achieve this goal, the facility staff must recognize an acute change of condition and identify its nature, severity, and cause(s). An approach to recognition, assessment, treatment, and monitoring of changes in condition should result in better management of these events and fewer transfers to hospitals and other acute care settings...Purpose: 1. To ensure that changes in a resident condition are identified and addressed timely. 2. To ensure that any resident with a change of condition is monitored for improvement, decline or potential complications. 3. To ensure development of an ISP (Individual Service Plan) to address the residents individual needs..."

On 06/13/2023, Surveyor reviewed the closed medical record of Resident 1. The face sheet indicated Resident 1 had a legal guardian and was admitted with diagnoses to include hypertension, diabetes, and muscle weakness. Resident 1's current ISP, last reviewed/revised on 03/22/2022, documented the resident required staff assistance for ADL's (Activities of Daily Living) and one staff for transfers. Additionally, the ISP indicated, "[Resident 1] uses a wheelchair most times and can propel the wheelchair without staff assistance. [Resident 1] is also able to walk with a two wheeled walker and stand-by assistance/supervision from staff. [Resident 1] can communicate without issues." On 06/13/2023 at 12:40 PM, Director of Operations A

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confirmed the above ISP was the most current ISP for Resident 1.

An ED (Emergency Department) report dated 05/07/2023, indicated Resident 1 presented to the ED at 11:58 PM for altered mental status and was admitted to the hospital for further evaluation. Resident 1's hospital admission history and physical indicated, "1. Sepsis-Positive urinalysis, likely source for now...[Resident 1] was brought in due to altered mental status and recent history of being lethargic. [Resident 1] is with dementia and cannot provide any other history." The hospital discharge summary indicated Resident 1 was discharged to a skilled nursing facility on 5/15/2023 with multiple diagnoses to include urinary tract infection and sepsis.

Review of Resident 1's Progress Notes indicated the following:

*04/29/2023 at 4:44 AM- "[Resident 1] remained up until about 4:25 AM. Resident was then assisted with transfers with 2 staff. Resident was unable/refusing to bear weight on either foot and when standing would appear to be as if [s/he] was squatting down. Resident was unable/unwilling to stand up straight as per [her/his] normal baseline...Resident did not give any reasoning as to why [s/he] was not able to stand or unwilling to stand and would just make what appears to be grunts and noises. Resident is now in bed..."

*05/02/2023 at 8:05 AM and 12:50 PM- "Resident transferred to toilet with 2 staff to assist...Resident uses a wheelchair and requires 2 staff for transfers using a pivot method. Staff uses a sit to stand when resident is weak..."

*05/04/2023 at 6:20 PM- "...Resident's Novolog

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was put on hold due to resident not wanting to eat..."

*05/07/2023 at 3:09 PM- "Resident assisted with toileting and changed. Writer and staff struggled severely with use of sit to stand, resident would not comply."

Resident 1's Vital Report documentation was reviewed which indicated the following:

*05/05/2023- Resident 1 consumed no breakfast or lunch meal. The supper meal percentage amount was not recorded/documented.

*05/06/2023- No breakfast, lunch or supper meal percentage amounts were recorded or documented.

*05/07/2023- No breakfast, lunch or supper meal percentage amounts were recorded or documented.

On 06/13/2023 at 11:30 AM, Surveyor interviewed RA (Resident Assistant)-C regarding Resident 1. RA-C indicated, Resident 1 required assistance from staff with ADL's, was able to feed her/himself during meals and able to communicate needs. RA-C stated, "A few days prior to [Resident 1's] hospitalization, [Resident 1] did not want to eat or feed [her/himself]. [Resident 1] was weak and didn't want to do anything. [Resident 1] usually colors, plays bingo and watches TV, but [s/he] would just sit in [her/his] wheelchair and sleep all the time, which was not normal for [her/him]. I tried to feed [Resident 1] but [s/he] would only eat 3 to 4 bites and that's it. We tried pushing fluids but [Resident 1] didn't want any...We had to use 2 staff to transfer [Resident 1] because [s/he] would

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not help with the transfers. When 2 staff tried to transfer [Resident 1] [s/he] would just drop [her/himself] and not put any weight on [her/his] feet to help pull [her/himself] up ... [Resident 1] was really weak." Surveyor then ask RA-C if the above information was reported to anyone. RA-C stated, "We're supposed to tell the med passer...I did tell one of the med passers about [Resident 1] changes and [Resident 1] not being [her/himself] several times prior to [Resident 1] going to the ED."

On 06/13/2023 at 2:30 PM, Surveyor interviewed RA-D regarding Resident 1. RA-D indicated, four to five days prior to Resident 1's hospitalization on 05/07/2023, the resident was "Acting differently." Surveyor asked RA-D to explain. RA-D stated, "[Resident 1] seemed really tired and out of it. It was unusual for [her/him] to be tired all the time. We would put food in front of [her/him] and [s/he] would just sit there and be in and out of sleep. [Resident 1] would normally eat all [her/his] food and feed [her/himself]...[Resident 1] didn't listen to you when you would talk to [her/him] and given [Resident 1] [her/his] medications became more difficult...I felt like [Resident 1] was different and told the med passer...I didn't chart the change or notify the guardian and/or physician."

On 06/14/2023 at 2:30 PM, Surveyor interviewed RA-F regarding Resident 1. RA-F indicated Resident 1 began showing signs of a decline four or five days prior to the 05/07/2023 hospitalization. RA-F stated, "Resident 1 started eating less and less and drinking less and less. [Resident 1's] mood was different, [s/he] was tired and weak, which was out of the ordinary. [Resident 1] became more resistive to toileting than normal. It typically takes 20 minutes to toilet

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N 169	Continued From page 9 [Resident 1], but the days leading up to sending [Resident 1] to the hospital it would take an hour to toilet [Resident 1] because of [her/his] decline in mood and transfer ability." Surveyor then asked RA-F who s/he reports to if a resident experiences a change in condition. RA-F indicated s/he would report to the med passer. On 06/14/2023 at 1 PM, Administrator B acknowledged the facility did not immediately notify Resident 1's guardian or Resident 1's physician when the resident experienced a physical change in condition including a decline in mood, a decrease in appetite, difficulty bearing weight and an increased need for assistance with transfers. Administrator B stated, "I would expect staff to notify the on call staff for direction and send the resident out sooner to the ED if need be."	N 169		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observations, record review and interviews, the provider did not ensure each resident received all prescribed medications in the dosage and at the intervals prescribed by a practitioner for 4 of 4 residents. Resident 5 had an order for Calcium 600 (calcium	{N 352}		

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carbonate), 1 tablet daily to be given during the AM (morning) medication pass. The medication was omitted.

Resident 6 had an order for a rivastigmine patch (medication to treat dementia). Staff were directed to remove the prior patch and place a new patch to the resident's skin daily. On 06/13/2023, Surveyor observed a rivastigmine patch located on Resident 6's left shoulder blade dated 06/11/2023. The patch was not removed and replaced with a new patch on 06/12/2023. Additionally, Resident 6's rivastigmine patch was not removed or replaced with a new patch from 12/17/2022 through 12/21/2022.

Resident 7 had a physician's order for aspirin 81 mg (milligram) tablet daily. Resident 7 did not receive the prescribed medication as ordered from 05/19/2023 through 05/25/2023, a total of 7 days.

On 03/06/2023, RA (Resident Assistant)-I administered another resident's medications to Resident 4. Resident 4 was sent to the ED (Emergency Department) and observed in the hospital overnight due to bradycardia.

This is a repeat deficiency. See Statement of Deficiency (SOD) F90311, dated 10/12/2022.

Findings include:

Example 1
On 06/13/2023 at 8:10 AM, Surveyor observed RA-H administer oral medications to Resident 5. Following the medication administration, Surveyor verified the medications given to Resident 5 against the current physician's orders. Surveyor noted the physician's order for calcium carbonate

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{N 352}	Continued From page 11 600 mg tablet once daily scheduled during the AM medication pass, was not administered to Resident 5. On 06/13/2023, during the above medication pass for Resident 5, RA-H did not acknowledge the order for the calcium carbonate tablet, look for the medication or indicate the medication was missing from the cart during Surveyor's observation. On 06/13/2023, Surveyor reviewed Resident 5's medical record. Resident 5 was admitted to the facility on 09/19/2022 with diagnoses to include diabetes and Alzheimer's. Additionally, the facility managed and administered all of Resident 5's medications. Review of Resident 5's MAR (Medication Administration Record) for June 2023 indicated Resident 5's calcium carbonate 600 tablet had not been administered by staff on 06/09/2023, 06/10/2023, 06/11/2023 and 06/12/2023. Surveyor also noted RA-H recorded the calcium medication was not administered on 06/13/2023 during the AM med pass because the "Drug was unavailable." On 06/13/2023 at 2 PM, Surveyor interviewed Director of Operations A regarding Resident 5's medication pass. Surveyor indicated to Director of Operations A not observing the calcium medication administered during the med pass. Director of Operations A and Surveyor went into the medication cart to observe Resident 5's medication blister packs. Director of Operations A verified the calcium carbonate medication was not in a blister pack or in the medication cart. Director of Operations A then went into a cabinet, within the medication room, pulled out a pink basin and located an over-the-counter bottle of calcium carbonate labeled for Resident 5.	{N 352}		

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{N 352}	Continued From page 12 Director of Operation A stated, "Staff probably have not been administering [Resident 5's] calcium tablet because it's not in a blister pack in the med cart...We're going to have to look into getting all over the counter medications into blister packs." Example 2 On 06/13/2023 at 9 AM, Surveyor observed a rivastigmine patch located on Resident 6's left shoulder blade dated 06/11/2023 with staff initials written on the patch in black marker. RA-G verified the patch located on Resident 6's left shoulder blade was dated 06/11/2023 with initials R.H. RA-G confirmed no other patch was located on Resident 6's skin. On 06/13/2023 at 9:30 AM, Surveyor observed RA-H prepare and place a rivastigmine patch to Resident 6's left shoulder blade. While placing the patch, RA-H noted the patch from 6/11/23 was still adhered to resident left shoulder blade. RA-H indicated an old patch was still on and should have been taken off and replaced on 06/12/2023. RA-H verified no other patch was found and stated, "A new patch should be applied daily...It was signed out yesterday by the med passer that it was removed and replaced with a new patch." On 06/14/2023, Surveyor reviewed Resident 6's medical record. Resident 6 was admitted to the facility on 09/30/2022 with diagnoses to include dementia and depression. Additionally, the facility managed and administered all of Resident 6's medications. The current physician orders indicated the resident was to have a rivastigmine patch applied to the skin once daily in the morning after removal of the prior patch.	{N 352}		

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A home health skilled nursing visit note for Resident 6, dated 12/21/2022 indicated, "[Resident 6] laying in bed upon arrival. Appears more confused than normal. Speaking in nonsensically sentences...Kept stating [s/he] didn't trust anyone [s/he's] scared and everyone lies to [her/him]...During skin assessment noticed [her/his] patch was old and dated 12/16/2022. Staff have reported increased confusion with resident and this could be the reason. Asked staff who was passing medications today if [Resident 6] received [her/his] morning medications and why [her/his] patch hasn't been replaced since 12/16/2022. Staff couldn't provide an explanation just shrugged shoulders and walked away from writer. Writer then went to [Administrator E] and explained that [Resident 6's] patch is old and could likely be contributing to [her/his] increased confusion that's been reported by staff. Writer then followed [Administrator E] to the med room where [s/he] took the patch out of the drawer opened it and handed it to staff and told staff to put it on [Resident 6]..."

Review of Resident 6's MAR for December 2022 indicated Resident 6's rivastigmine patch was signed out as administered on 12/17/2022 through 12/20/2022. Surveyor also reviewed Resident 6's MAR for June 2023 and noted staff had signed out Resident 6's rivastigmine patch as administered on 06/12/2023.

On 06/13/2023 at 1 PM, Surveyor interviewed Director of Operations A and Administrator B regarding the above skilled nursing visit note related to Resident 6's rivastigmine patch. Administrator B indicated s/he recalls a conversation s/he had with the nurse from home health regarding Resident 6's patch. Administrator B stated, "The nurse reported to me

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sometime in December 2022 that [Resident 6's] patch was not changed in 3 days. I had the med passer change the patch that day and disciplined the med passer, but I can't find the documentation." Surveyor then discussed the current observation of the medication pass for Resident 6. Surveyor indicated Resident 6's rivastigamine patch was not removed and/or replaced on 06/12/2023, but was signed off as being removed and administered. Director of Operations A stated, "We'll be putting a corrective action plan in place today."

Example 3
On 6/14/2023, Surveyor reviewed Resident 7's medical record. Resident 7 was admitted to the facility on 07/06/2022 with diagnoses to include diabetes, hypertension and heart disease. Additionally, the facility managed and administered all of Resident 7's medications.

Resident 7 had a physician's order dated 07/06/2022 which indicated, "Aspirin 81 mg tablet daily once every morning."

Per Review of Resident 7's May 2023 MAR, Surveyor noted the aspirin had not been administered by staff on 05/19/2023,0 5/20/2023, 05/21/2023, 05/22/2023, 05/23/2023, 05/24/2023, and 05/25/2023 because the "Drug was unavailable." Resident 7 did not receive the prescribed aspirin medication as ordered for 7 days.

On 06/14/2023 at 11:25 AM, Surveyor interviewed Director of Operations A regarding Resident 7's aspirin medication. Director of Operations A verified Resident 7 did not receive the aspirin medication on the above dates due to the medication "Not being in the building." Director of

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{N 352}	Continued From page 15 Operations stated, "We're looking into working with a different pharmacy to ensure we have medications available." Example 4 On 06/14/2023, Surveyor reviewed Resident 4's medical record. Resident 4 was admitted to the facility on 02/24/2020 with diagnoses to include muscle weakness and atrial fibrillation. Additionally, the facility managed and administered all of Resident 4's medications. Review of Resident 4's progress notes revealed the following: *03/06/2023 at 9:32 AM- "Writer was notified this morning by [RA-I] regarding a medication error. Resident received another residents medications. Writer inquired about medications resident received. Due to the affects of some medications that resident received as well as advanced age, it was recommended that staff send resident to the emergency room for further evaluation." *03/06/2023 at 6:52 PM- "Writer called down to ED for a status up date on resident. Writer was informed by nurse resident was going to be admitted tonight. [Her/his] heart rate is staying between 40-50 due to medication [s/he] received this morning. Poison control stated that they want [her/him] to stay overnight to be monitored..." Review of a medication error report for Resident 4 dated 03/08/2023 indicated RA-I was the individual responsible for the error. Additionally the report indicated, "[RA-I] called around 8 AM on 03/06/2023 stating that [s/he] had put the wrong residents medication on this resident's breakfast tray and [s/he] took the medications. [RA-I] was instructed to notify nurse and	{N 352}		

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{N 352}	Continued From page 16 responsible party. [Resident 4] was sent to the ED for evaluation...[Resident 4] had a lower than normal pulse and stayed overnight at the hospital." A hospital after visit summary for Resident 4 indicated the resident was admitted to the hospital on 03/06/2023 and discharged on 03/07/2023 for "Medication administered in error: accidental or unintentional." On 06/14/2023 at 1 PM, Surveyor interviewed Administrator B regarding the above medication for Resident 4. Administrator B acknowledged the medication error occurred and stated, "[RA-I] was removed from the medication cart and [his/her] med training was rescinded following this error."	{N 352}		
{N 481}	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and staff interview the provider did not ensure all common living areas were clean. Carpets in Residents 2 and 3's rooms had not been cleaned. Dead bug carcasses remained in 1 of 2 hallway windows. This is a repeat deficiency from SOD (Statement of Deficiency) F9O311 dated 10/12/2022.	{N 481}		

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{N 481}	Continued From page 17 Findings include: On 06/14/2023 at approximately 12:45 PM Surveyor toured the facility and observed the following: 1) The carpets in Residents 2 and 3's rooms were stained with ground in dirt. Resident 2's carpeting had numerous stains in front of the bathroom. 2) One of two windows at the end of the hallway by room 24 still had dead bug carcasses in it. On 06/14/2023 at approximately 3:00 PM, Surveyor conducted an interview with DIR (Director of Operations) - A and ADM (Administrator) - B who confirmed these areas had not been cleaned.	{N 481}		
{N 667}	83.59(7)(b) Required exit signs lighted All required exit signs shall be lighted at all times. This Rule is not met as evidenced by: Based on observation and staff interview the provider did not ensure all required exit signs were lighted at all times. The main front exit from the facility had no exit sign. This is a repeat violation from SOD (Statement of Deficiency) F9O311, dated 10/12/2022. Findings include: This provider was issued a regular license on 03/05/2020, as a Class CNA (non-ambulatory) community based residential facility (CBRF), able to serve up to 30 residents within the client	{N 667}		

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{N 667}	Continued From page 18 groups of: irreversible dementia/Alzheimer's, physically disabled and advanced aged. On 06/13/2023 at approximately 9:00 AM Surveyor observed there was no exit sign over the main entrance/exit of the facility where required. The facility's exit diagram listed this as one of the main designated exits. On 06/14/2023 at 12:45 PM, Surveyor interviewed DIR (Director of Operations) - A and ADM (Administrator) - B about the missing exit sign. DIR - A confirmed there was never an exit sign there and confirmed the exit diagram lists it as a main designated exit in case of emergency evacuation.	{N 667}		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on observation, record review and	Y3244		

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interviews, the provider did not ensure Resident 4 received adequate and appropriate care within the capacity of the facility.

Resident 4 had a recent history of a UTI (urinary tract infection) on 04/02/2023. During the provision of incontinence cares for Resident 4, RA (Resident Assistant)-G did not provide appropriate perineal care to maintain good personal hygiene and prevent urinary tract infections.

Findings include:

The facility's policy and procedure regarding incontinence care revised on 03/01/2013 indicated, "The staff at the facility will provide prompt assistance to any resident who has been incontinent of urine or feces..."

On 06/14/2023, Surveyor reviewed Resident 4's medical record. Resident 4 was admitted to the facility on 02/24/2020 with diagnosis to include muscle weakness, hypertension, and osteoporosis. Additionally, Resident 4's medical record indicated on 02/20/2023, the resident was diagnosed with a UTI and placed on a 7-day course of antibiotic therapy. The record also showed Resident 4 was diagnosed with a UTI on 04/02/2023 and placed on a 5-day course of antibiotic therapy.

On 06/14/2023, Surveyor reviewed Resident 4's most current ISP (Individual Service Plan) last reviewed/revised on 03/29/2022 which documented, the resident is independent with ADL's (Activities of Daily Living) but at times needs some assistance with cares. Approaches listed on the ISP stated, "Staff will remind [Resident 4] and offer assistance to complete

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personal cares...Staff will allow [Resident 4] to be independent but assist when [s/he] needs it." On 03/31/2023 the provider initiated 2 hours checks for staff to check Resident 4's bed and brief for incontinence.

On 06/13/2023 at 10:15 AM, Surveyor observed Resident 4 sitting up on the edge of her/his bed requesting help for toileting assistance. At 10:17 AM, RA-G walked into Resident 4's bedroom and assisted the resident into her/his wheelchair. (***Surveyor noted a washable chux pad on Resident 4's bed was covered with brown ring stains.) Resident 4 was wheeled into the bathroom and RA-G removed a soiled brief from the resident before assisting the resident to sit on the toilet. Loose stool dripped out of Resident 4's soiled brief onto the bathroom floor. Resident 4 was incontinent of a large amount of loose stool and RA-G verbally confirmed Resident 4's brief contained a large amount of loose stool. While Resident 4 was sitting on the toilet, RA-G retrieved a pink basin and one wash cloth from Resident 4's cabinet. RA-G assisted Resident 4 off the toilet to a standing position. Resident 4 was holding onto a walker with both hands and unable to perform her/his own personal cares. RA-G wiped Resident 4's rectal area with the washcloth several times, without cleansing the groin folds, genitals or frontal perineal area that had contact with the loose stool in the brief. RA-G then applied a clean brief and assisted Resident 4 back to the wheelchair. Surveyor observed a smear of feces on the back of Resident 4's leg that had not been cleaned. Surveyor questioned RA-G if s/he had finished incontinence cares for Resident 4. RA-G confirmed s/he was done providing cares for Resident 4. Surveyor immediately questioned RA-G regarding the observation of care with

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Resident 4 and asked if staff were expected to provide frontal peri-care after a resident had been incontinent of stool. RA-G verified s/he had not performed any frontal peri-care on Resident 4 and stated, "I usually provide frontal peri-care when the resident is laying down in bed...I only had one washcloth and couldn't find any additional washcloths...I didn't want to use that same washcloth to clean [Resident 4's] front area." Surveyor then asked RA-G if s/he received task specific training in toileting and incontinence care. RA-G stated, "This is my first job in healthcare. Another staff showed me how to do incontinence care on a resident laying down in bed, but not standing up." Surveyor voiced concerns to RA-G that frontal peri-care was not completed and stool was still present on Resident 4's leg. At that time RA-G requested help from RA-C. RA-C came into the room and changed Resident 4's bedding and placed a new washable chux pad on Resident 4's bed. (***Surveyor noted the new clean washable chux pad had multiple brown ring stains.) Surveyor asked RA-C if the chux pad was clean. RA-C stated, "Yes ...[Resident 4's] chux pads are supposed to be white in color, but [Resident 4's] pads are really stained. We tried soaking [her/his] pads in vinegar and bleach to get the stains out but nothing works...[Resident 4's] chux pads are stained so bad staff don't know if it's wet or dirty. We've told management about it and were told insurance was responsible to replace them." Once the bed was cleaned and made Resident 4 laid down in her/his bed. Resident 4 was then provided frontal peri-care and the stool was cleaned off the back of the resident's leg by RA-C and RA-G, after being asked by Surveyor.

On 06/14/2023 at 1:50 PM, Surveyor interviewed Director of Operations A and Administrator B

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Y3244	Continued From page 22 regarding the above observation. Director of Operations A provided training records for RA-G indicating, RA-G received training in provision of personal cares including toileting and incontinence care. Administrator B then stated, "We would expect staff to provide frontal perineal care for residents who are incontinent."	Y3244		