STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019249	A. BUILDING: _____ B. WING _____	C 04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE SENIOR LIVING	3172 OLD TOWN ROAD EAU CLAIRE, WI 54701

(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 On 02/27/2024, Surveyor conducted 4 complaint investigations at Cambridge Senior Living. One additional complaint was received on 03/12/2024. Data collection continued through 04/12/2024. Two of the 5 complaints were substantiated. Seven deficiences were identified. One of the 7 deficiencies was a repeat deficiency. See Statement of Deficicency (SOD) OEMO11, dated 06/16/2023). Census: 57	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.	N 158		

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

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N 158	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct a thorough investigation and take immediate steps to protect residents from further harm and report findings for all missing money allegations that occurred between 02/08/2024 and 03/13/2024. Findings include: On 03/12/2024, the Department received a complaint of missing money. "The Wisconsin Background Check and Misconduct Investigation Program Manual," https://www.dhs.wisconsin.gov/publications/p0/p00038.pdf, with a revision date of 01/2024, states, in part: "ENTITY INTERNAL INVESTIGATION RESPONSIBILITIES All entities regulated by DQA must conduct a thorough internal investigation and document the findings for all allegations or incidents at the entity. A thorough internal investigation may include: o Collecting and preserving any physical and documentary evidence including videos; o Interviewing alleged victims and witnesses; o Collecting other corroborating/disproving evidence; o Involving other regulatory authorities who can assist (e.g., local law enforcement, elder abuse agency, Adult Protective Service agency, DQA, Board on Aging Ombudsmen, Client Right's Specialist, etc.); and o Documenting each step taken during the internal investigation.	N 158		

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N 158	Continued From page 2 ...Protection of Clients Immediately upon learning of the incident, the entity must take necessary steps to protect clients from possible subsequent incidents of misconduct or injury. Notifying Law Enforcement In addition to DQA reporting requirements, entities are required to notify local law enforcement authorities in any situation where there is a potential criminal offense. Entity Internal Investigative Report The entity must investigate any allegation, incident, or suspected occurrence of misconduct. A timely and thorough entity investigative report is required. An internal investigative report provides: o A record of the entity's internal investigator's activities and findings so that nothing is left to memory Wis. Admin. Code § DHS 13.05(3) Wis. Admin. Code § DHS 13.05(2) The Wisconsin Background Check and Misconduct Investigation Program Manual Page 37 of 44 For Entities Regulated by the Division of Quality Assurance P-00038 (01/2024) o A permanent official record of the entity's internal investigator's actions, observations, and discoveries o A basic reference of the case o Information on what has been done concerning the case o A basis for deciding further action o A method to communicate the findings of the case o Information that can be evaluated and analyzed to detect and identify patterns of conduct." On 03/14/2024, Surveyor emailed Administrator D and asked for all reports of missing money. Administrator D identified Resident 3, Resident 5 and Resident 6 with having missing money reports and informed Surveyor police were notified of all allegations. Administrator D emailed	N 158		

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N 158	Continued From page 3 Surveyor the Misconduct Incident Reports (MIR) submitted to the Department and the facility "investigation summary" documents s/he had available for review for each resident. The following information was retrieved from the MIR document and the provider "investigation summary" notes: RESIDENT 5 -Reported $271, and a $100 gift card was missing on 02/08/2024. -Resident was interviewed on 02/08/2024 and 02/13/2024. -Staff interviews were conducted on 02/13/2024 and 02/14/2024, 5 days after money was reported missing. -On 02/13/2024, Administrator D met with police, 5 days after money was reported missing. -Conclusion: Money was reimbursed by the facility to equal the amount of the total cash and gift card that was missing. Resident was educated on the ability to use the facility trust fund system. RESIDENT 6 -Reported $130 was missing on 02/11/2024. -Resident was interviewed on 02/12/2024, 1 day after money was reported missing -Staff interviews were conducted on 02/13/2024 and 02/14/2024, 2 days after money was reported missing. -Conclusion: Money was reimbursed by the facility and resident was educated on the ability to use the facility trust fund system. RESIDENT 3 -Reported approximately $700 missing on 02/15/2024 from a white banking envelope stored in his/her nightstand.	N 158		

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N 158	Continued From page 4	N 158		

-Resident 3 was interviewed by Administrator D on 02/15/2024 and 02/16/2024 and could not determine the exact amount or a specific date the money went missing. Administrator D searched Resident 3's room and was unable to locate any cash that may have been misplaced.
-Police were involved.
-Staff were not interviewed following Resident 3's report of missing money.
-Conclusion: Resident was educated on the ability to use the facility trust fund system. Resident was not interested in using it. Provider suggested resident and family should purchase a small safe for Resident 3's room.

The report provided by Administrator D for Resident 3's missing money indicated local police were involved, but the police report retrieved on 04/02/2024 showed Administrator D contacted the police on 03/15/2024 to report this incident, approximately 30 days later.

INTERVIEWS

On 03/14/2024 at approximately 2:45 PM, Surveyor interviewed Resident 3 via phone. Resident 3 stated s/he was his/her own decision maker and resided in an apartment at the facility with his/her spouse. Resident 3 stated s/he reported missing money to Administrator D in the range of $650 to $750 on 02/15/2024. Resident 3 stated Administrator D informed him/her s/he would look into it. Resident 3 further stated, "I never heard back from [him/her] (Administrator D) and the police never followed up, so I don't know what the status is." Resident 3 stated s/he felt his/her concerns were not followed up on.

On 04/02/2024 at 11:00 AM, Surveyor discussed with Administrator D, the concern that Resident

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N 158	Continued From page 5 3's missing money was not investigated. Administrator D stated s/he offered Resident 3 alternatives to keeping his/her money safe by educating him/her on the facility trust fund system, and recommended Resident 3 purchase his/her own safe. Administrator D stated, "We can't force the police to come in here; we did our due diligence." Administrator D further stated s/he had already conducted staff interviews for similar allegations of missing money and did not interview staff again, specifically for Resident 3's missing money. POLICE REPORTS On 03/14/2024, Surveyor requested police reports from the local law enforcement office as Administrator D reported the police were involved for all allegations including Resident 3, and all reports were properly investigated. The police report retrieved showed Administrator D did not notify police of Resident 3's missing money until 03/15/2024, approximately 30 days after Resident 3 reported missing money. On 04/02/2024, Surveyor requested an updated police report for all reports of missing money at the facility address. Disposition notes on 03/15/2024 stated Administrator D reported 2 additional thefts of missing money had occurred; one on 02/15/2024 that matched Resident 3's report of missing money, and a fourth report of missing money (Resident 4) for "several rolls of quarters" on 03/13/2024. The fourth report of missing money was not disclosed by the provider throughout the	N 158		

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N 158	Continued From page 6 investigation, and was discovered after retrieving an updated police report. On 04/04/2024 at approximately 2:00 PM, Administrator D informed Surveyor the fourth report of missing money was reported by Resident 4 on 03/13/2024, and stated it was not investigated. SUMMARY The provider did not conduct a thorough investigation or take immediate steps to protect residents when 4 reports of missing money were filed between 02/08/2024 and 03/13/2024. Staff interviews were delayed 5 days after the initial report of missing money was filed on 02/08/2024, and 2 days after the second report of missing was money filed on 02/11/2024. Law enforcement was present at the facility on 02/13/2024, approximately 1 and 2 days after the missing money was reported Staff interviews were not conducted following Resident 3's report of missing money filed on 02/15/2024, and law enforcement was notified on 03/15/2024, approximately 30 days after the report was filed. Staff interviews were not conducted following Resident 4's report of missing money on 03/13/2024, and Resident 4's missing money was not investigated. Cross Reference N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment	N 158		

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N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were free from financial exploitation and misappropriation of property when 4 allegations of missing money were reported to Administrator D between 02/08/2024 and 03/13/2024. Findings include: On 03/12/2024, the Department received a complaint of missing money. On 03/14/2024, Surveyor emailed Administrator D and asked for all reports of missing money. Administrator D identified Resident 3, Resident 5 and Resident 6 with having missing money reports and informed Surveyor police were notified of all allegations. Administrator D emailed Surveyor the Misconduct Incident Reports (MIR) submitted to the department and the facility "investigation summary" documents s/he had available for review for each resident. The following information was provided: Resident 5	N 348		

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N 348	Continued From page 8	N 348		

-Reported $271, and a $100 gift card was missing on 02/08/2024.
-Resident was interviewed on 02/08/2024 and 02/13/2024.
-Staff interviews were conducted on 02/13/2024 and 02/14/2024, 5 days after the report of missing money.
-On 02/13/2024, Administrator D met with police, 5 days after the report of missing money.
-Conclusion: Money was reimbursed by the facility to equal the amount of the total cash and gift card that was missing. Resident was educated on the ability to use the facility trust fund system.

Resident 6
-Reported $130 was missing on 02/11/2024.
-Resident was interviewed on 02/12/2024, 1 day after the report of missing money.
-Staff interviews were conducted on 02/13/2024 and 02/14/2024, 2 days after the report of missing money.
-Conclusion: Money was reimbursed by the facility and resident was educated on the ability to use the facility trust fund system.

Resident 3
-Reported approximately $700 missing on 02/15/2024.
-Staff were not interviewed following Resident 3's report of missing money.
-Police were involved.
-Conclusion: Resident was educated on the ability to use the facility trust fund system. Resident was not interested in using it. Provider suggested resident and family should purchase a small safe for Resident 3's room.

The report provided by Administrator D for Resident 3's missing money indicated local police

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N 348	Continued From page 9	N 348		

were involved, but the police report retrieved on 04/02/2024 showed Administrator D contacted the police on 03/15/2024 to report this incident, ~ 30 days later.

POLICE REPORTS

On 03/14/2024, Surveyor requested police reports from the local law enforcement office as Administrator D reported the police were involved for all allegations including Resident 3, and all reports were properly investigated. The police report retrieved showed Administrator D did not notify police of Resident 3's missing money until 03/15/2024, approximately 30 days after Resident 3 reported missing money.

On 04/02/2024, Surveyor requested an updated police report for all reports of missing money at the facility address. Disposition notes on 03/15/2024 stated Administrator D reported 2 additional thefts of missing money had occurred; one on 02/15/2024 that matched Resident 3's report of missing money, and a fourth report of missing money (Resident 4) for "several rolls of quarters" on 03/13/2024.

The fourth report of missing money was not disclosed by the provider throughout the investigation, and was discovered after retrieving an updated police report.

On 04/04/2024 at approximately 2:00 PM, Administrator D informed Surveyor the fourth report of missing money was reported by Resident 4 on 03/13/2024, and stated it was not investigated.

INTERVIEW

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N 348	Continued From page 10 On 04/04/2024 at approximately 2:00 PM, Administrator D and RD E stated an all-staff training had not been completed or offered regarding topics related to resident rights or misappropriation. Administrator D informed Surveyor staff meetings were scheduled throughout the month, and stated s/he spoke to each employee individually during the staff interviews conducted on 02/13/2024 and 02/14/2024 and told staff to report any concerns immediately. SUMMARY The provider did not ensure residents were free from financial exploitation and misappropriation of property when 4 allegations of missing money were reported to Administrator D between 02/08/2024 and 03/13/2024. Staff interviews were delayed 5 days after the first allegation of missing money was reported to Administrator D. As of 04/04/2024, the provider did not take action in reviewing or implementing policies and procedures in response to multiple reports of missing money. Immediately addressing the initial theft on 02/08/2024 may have prevented further misappropriation victimizing Resident 3, Resident 4 and Resident 5. Cross Reference N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse And Neglect	N 348		
N 356	83.32(3)(l) Rights of Residents: Least restrictive env In addition to the rights under s. 50.09, Stats.,	N 356		

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N 356	Continued From page 11 each resident shall have all of the following rights: Least restrictive environment. Have the least restrictive conditions necessary to achieve the purposes of the resident ' s admission. The CBRF may not impose a curfew, rule or other restriction on a resident ' s freedom of choice. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure residents had the least restrictive conditions necessary to achieve the purposes of the resident's admission. The provider established and posted visiting hours. The provider also required residents to return to the facility by an established curfew. Findings include: On 02/27/2024 at approximately 8:00 AM, Surveyor approached the entrance to the facility and attempted to enter the facility. The front door was locked and alarmed with delayed egress. A sign was posted on the door that read, "WELCOME! From all of us here at Cambridge Senior Living, thank you for visiting us today! Please ring the doorbell and someone will assist you momentarily. Please note that our visiting hours are from 9:00AM - 7:00PM. In emergent situations only, please reach out to our Manager-on-Duty directly using the number listed below." The manager-on-duty's phone number was listed to call. At approximately 11:45 AM, Surveyors interviewed Caregiver C. When asked about the visiting policy and hours posted on the provider's front door, Caregiver C stated the provider would	N 356		

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make exceptions for residents that were actively passing away. Caregiver C stated s/he could not recall seeing visitors in the building before 9:00 AM.

At 2:39 PM, Surveyors interviewed Administrator D and Regional Director (RD) E. When Surveyors asked about the visiting hours posted on the front door, Administrator D stated they do not enforce the visiting hours. When asked about the visitation hours that were noted in the admission agreement, Administrator D stated they would be rewriting the admission agreement and updating the verbiage used regarding visiting hours.

On 03/04/2024, Surveyors requested additional documentation from Administrator D and (RD) E via email.

On 03/05/2024, Administrator D provided additional documentation via email that included an admission agreement for Resident 2. The "Visitation" section of the admission agreement read, in part, "Family, friends, and other visitors are encouraged to visit you at our community. We request visitors provide advanced notice so that their visit can be accommodated. Lodging is not provided at our community, but the Holiday Inn Express is adjacent to our building and offers discounted rates for our guests ...Visitation is encouraged between the hours of 9:30 AM and 8:00 PM. Based on individual circumstances, other hours can be arranged with advanced notice." The "Independent Community Access" section of the admission agreement read, "Residents who demonstrate responsibility, good judgement and safety awareness may receive independent community access based on approval from your Legal Responsible Party and it is listed in your ISP (individual service plan). If

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N 356	Continued From page 13 you have community access you must follow the Sign In/Out Procedures described on page 32, discuss with the Executive Administrator/designee your destination and activity, method of transportation, and time returning. Independent Community Access is permissible between the hours of 9:00am and 7:00pm, unless prior approval was made and documented by the Executive Administrator/designee." On 03/12/2024, at 10:00 AM, Surveyors interviewed Administrator D and RD E. When asked about the community access pass referenced in the admission agreement, RD E stated there were quite a few factors that would go into implementing a community access pass. RD E stated they did not have any residents that utilized the pass.	N 356		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care.	N 386		

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CAMBRIDGE SENIOR LIVING	3172 OLD TOWN ROAD EAU CLAIRE, WI 54701

(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 386	Continued From page 14 This Rule is not met as evidenced by: Based on record review and interview, the provider did not develop an individualized service plan (ISP) for Resident 2 to identify his/her needs, desired outcomes, program services, frequency, and approaches, regarding urinary catheter care and falls. This is a repeat deficiency. See Statement of Deficiency (SOD) OEMO11, dated 06/16/2023. Findings include: On 01/16/2024, the department received a complaint alleging resident care needs were not being met by the provider. On 02/27/2024, Surveyors conducted an on-site visit and requested Resident 2's record. At 11:35 AM, Surveyors interviewed Caregiver C. Caregiver C stated s/he would change Resident 2's catheter bag when s/he was the scheduled medication passer. Caregiver C stated there had been confusion expressed by staff about who should change the catheter bags and when the bags should be changed. On 03/04/2024, Surveyors requested additional documentation from Administrator D and Regional Director (RD) E via email. On 03/05/2024, Administrator D provided additional documentation via email for review that included the following: -Resident 2's date of admission was 11/21/2023. S/he was diagnosed with benign prostatic hyperplasia, glaucoma, constipation, and	N 386		

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hypotension.

-A pre-admission health assessment, dated 11/13/2023, indicated Resident 2 had a fall resulting in deconditioning within the last 6 months. The assessment stated Resident 2 utilized a catheter and required assistance to manage it.

-A fall risk assessment for Resident 2, dated 11/21/2023, with a score of 55. A resident with a score of 45 and higher was identified to be a high fall risk.

The ISP, dated 12/19/2023, included a section titled, "CATHETER," with a goal that stated, "Home Health/Hospice will assist [Resident 2] with maintaining [his/her] catheter." Under the "Interventions" section, it stated, "[Resident 2] receives assistance through Home Health to maintain ordering, refilling, and changing his/her catheter. Staff will provide assistance with catheter care as needed. Staff will notify Home Health Nurse/physician with changes in catheter as needed." Under a section titled, "MOBILITY," there was a goal of, "[Resident 2] will receive reminders and cues for safety for mobility." Under the "Interventions" section, it stated, in part, "[Resident 2] needs reminders and cues with all bed mobility, transfers, and ambulation. [S/he] utilizes a 4WW (4 wheeled walker) for all mobility needs. [Resident 2] may ambulate independently away from facility grounds and does not need to be accompanied by staff." Under the "COGNITION" section, it stated Resident 2 had an activated health care power of attorney.

On 03/12/2024, at 10:00 AM, Surveyors interviewed Administrator D and RD E. Administrator D stated the ISP, signed on

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N 386	Continued From page 16 12/19/2023, was Resident 2's 30-day ISP. When asked why Resident 2's fall risk status was not identified on the ISP, Administrator D stated Resident 2's fall risk status was visible to staff on a dashboard that included special instructions. Administrator D stated Resident 2's fall risk status would also be found on his/her face sheet. When asked why the ISP stated Resident 2 could ambulate away from facility grounds without staff supervision, RD E stated that likely referenced the courtyard area of the facility and staff are taught that residents with a high fall risk should not be left alone. When asked about the catheter care expectations for staff, RD E stated they would have the home health agency or hospice do all of the catheter bag changes, including if residents needed a tubing change or sediment was found in the bag. When asked about Resident 2's enrollment with the home health agency, RD E stated that once a month was typical for the agency to visit residents to provide care. RD E stated it would be staff's responsibility and standard of care to clean and empty the bags. Resident 2's ISP did not accurately capture the provider's responsibility for monitoring and completing daily catheter care maintenance and who was responsible for completing tasks associated with catheter changes. It did not identify the frequency in which the urinary catheter should be emptied and cleaned. The ISP did not indicate Resident 2 was a high fall risk and did not provide clarification why Resident 2 was identified as safe to ambulate from facility grounds without staff supervision. Cross Reference N0431 DHS 83.38(1)(g) Health Monitoring N0389 DHS 83.35(3)(d) Service Plans updated	N 386		

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N 386	Continued From page 17 Annually or On Changes	N 386		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 2 of 2 residents' (Resident 1 and Resident 2) individual service plans (ISP) were updated when there was a change in service needs. Resident 1's ISP was not updated to reflect catheter care provided by staff. Resident 2 was seen in the emergency room and diagnosed with a urinary tract infection (UTI). Resident 2's medical administration record (MAR) was updated to include catheter care needs but they were not updated in the ISP. Findings include:	N 389		

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N 389	Continued From page 18 On 02/27/2024, Surveyors conducted an onsite visit and requested Resident 1 and Resident 2's records. RESIDENT 1 Resident 1 had an admission date of 12/05/2022 and had the following diagnoses: Atrial fibrillation and flutter, vitamin B12 deficiency anemia, hypothyroidism, benign prostatic hyperplasia, intrinsic (allergic) eczema, legal blindness, dementia, anxiety, osteoarthritis, and unspecified macular degeneration. On 02/27/2024, Surveyor requested Resident 1's most current ISP. The ISP received from the provider was dated and signed on 05/16/2023. It read, in part: -Catheter Care: Goal- Home Health ("Home Health" was crossed out) will assist [Resident 1] with maintaining [his/her] catheter. [Resident 1] will be free of complications of catheter use. Interventions- [Resident 1] receives assistance through Home Health to ("Home Health to" was crossed out) maintain ordering, refilling, and changing [his/her] catheter. Staff will provide assistance with catheter care as needed. Staff will notify Home Health Nurse/physician with changes in catheter as needed. On 02/27/2024, Surveyor requested all documentation related to Resident 1's catheter care including, staff charting, progress notes, and orders for catheter care. On 03/07/2024, Surveyor received progress notes and a catheter care order via email from RD E. The order for catheter care, dated 04/28/2023, read, " [Hospice agency] RN	N 389		

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(registered nurse) to change leg and bedtime drainage bags monthly." No orders for daily care were received.

INTERVIEWS

On 02/27/2024 at 9:20 AM, Surveyor interviewed Caregiver J and Caregiver K. Caregiver J stated s/he was training when Resident 1 was still living there so s/he did not care for him/her frequently. Caregiver K stated, "[S/he] was always agreeable. [His/her] skin was very thin, very red, was on a steroid for that. It tore easily and bruised easily." Caregiver K reported staff charting was "very bare bones," and explained that staff don't get to chart in resident records. Caregiver K further stated that Resident 1 had several falls, some assisted falls because s/he lost his/her balance. Caregiver K stated Resident 1 did not ambulate and was transferred with 1 assist with gait belt from walker to wheelchair. Caregiver K stated 2 of the falls occurred while getting out of bed due to a lack of strength to stand. Caregiver K stated Resident 1 had a catheter and s/he would empty it in the morning and switch out the leg bag and empty again at 2:00 PM. Caregiver K stated Resident 3 requested a [soda] with ice every day at that time. Caregiver K informed Surveyor that they don't track input or output for residents with catheters, and staff do not record meal intake amounts.

On 02/27/2024 at 11:30 AM, Surveyor interviewed Caregiver C via phone and asked about Resident 1's cares. Caregiver C stated there was some confusion regarding who was responsible for catheter care (the caregiver assigned cares or the medication passer). Caregiver C stated staff were responsible for daily "emptying the bag, using an alcohol swab (to clean the drain spout),

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changing out the night and day bags, cleaning the tube, rinsing the bags with vinegar using a syringe plunger, rinsing the bag and hanging it to dry." Caregiver C stated there was nothing scheduled on the medication administration record (MAR) to reflect this process or the ISP and reported the catheter bag should be emptied more frequently. Caregiver C stated some staff would empty the bag and not rinse properly. Caregiver C stated Resident 1's skin was very thin and fragile and s/he remembered seeing his/her back bandaged up. Caregiver C stated, "You needed to treat [him/her] like a fragile egg."

On 03/12/2024 at approximately 10:00 AM, Surveyor discussed the above concerns with Administrator D and RD E via phone and asked what responsibilities staff had for Resident 1's catheter care. Administrator D and RD E explained their expectation similar to what Caregiver C reported. Surveyor asked Administrator D and RD E if orders were available for Resident 1's daily catheter care. Administrator D stated s/he would have to review the record and would send by the end of the day.

On 03/12/2024 at approximately 10:30 AM, Surveyor asked Administrator D and RD E if the ISP received on 02/27/2024 was the most current (as requested) ISP on file. Administrator D stated the ISP provided was a "significant change' ISP update and would get the most current ISP sent."

On 03/12/2024 at 10:42 AM, RD E emailed Surveyor Resident 1's ISP, with a date of 02/27/2024. The ISP showed this date was the "last service plan review completed." The ISP read, in part:

-Catheter: Resident 1 receives assistance

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through [hospice company] to maintain ordering, refilling, and changing [his/her] catheter. Staff will provide assistance with catheter care as needed. Staff will notify Hospice Nurse/physician with changes in catheter care as needed.

The ISP was not updated to reflect the daily catheter care staff provided to Resident 1.

On 03/12/2024 at approximately 10:45 AM, Surveyor reviewed the 10/02/2023 progress note with Administrator D via phone. The progress note documented family concerns regarding Resident 1's catheter care. Resident 1's family requested further staff training for gait belt transfers and catheter bag drainage and changing. Administrator D stated, "Hospice did staff education on proper cleaning and placement on October 2nd." Surveyor requested training documentation to show who provided the training, duration, and staff names of who attended the training. Administrator D stated s/he would have to look for the documentation.

On 03/12/2024 at 11:01 AM, Administrator D forwarded to Surveyor, an email chain, dated 10/01/2023, s/he had received from Resident 1's family regarding concerns with catheter placement for proper drainage, and gait belt use with transfers for mobility assistance. The email chain showed a response from the Registered Nurse (RN) case manager for the hospice agency responded to Resident 1's family concerns, stating, "I wrote an order for this as well to be added to [his/her] care plan last week Wednesday and it was processed." The email chain showed a response from RD E on 10/02/2023, instructing Administrator D to address Resident 1's family concerns "facility wide" (with all staff) and asked the hospice RN

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N 389	Continued From page 22 Case Manager if s/he could provide any training. On 10/02/2023, RN Case Manager replied to RD E's email and stated, "I sure can do training, I have given staff education regarding catheter bag cleaning and proper placement. I also have done training with a few staff on gaitbelt [sic]." Training documentation was not available to show it was completed on 10/02/2023, as reported by Administrator D during the interview on 03/12/2024. Resident 1's ISP was not updated to reflect daily catheter care provided by staff and did not include directions for staff on the frequency of emptying, cleaning, or changing the bag. Resident 2 Resident 2 was admitted to the facility on 11/21/2023, with a urinary catheter and diagnoses of dementia, acute kidney injury, and obstruction/lower urinary tract symptoms. On 02/27/2024, at 9:32 AM, Caregiver B provided catheter care assistance to Resident 2. Caregiver B removed the overnight catheter bag and attached a leg catheter bag to Resident 2's leg. After the leg catheter bag was attached, Caregiver B placed the overnight catheter bag that contained urine in Resident 2's bathroom. Caregiver B hung the catheter bag on a handrail next to the toilet. Caregiver B did not measure the urine output, pour out the urine, or clean the catheter bag. On 03/04/2024, Surveyors requested additional documentation from Administrator D and Regional Director (RD) E via email.	N 389		

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N 389	Continued From page 23 On 03/05/2024, Administrator D provided additional documentation via email that included the following: -A fall risk assessment, dated 11/21/2023, with a score of 55. A score of 45 and higher was identified to be a high fall risk. -An order for catheter care on Resident 2's February 2024 MAR with a start date of 02/27/2024 at 1900 hours. The order stated, "Foley Catheter Care should be completed during all three shifts, including peri/catheter care and emptying of catheter bag. three [sic] times a day for Maintenance [sic]." The March 2024 MAR included an additional order with a start date of 03/05/2024, that stated, "Put leg bag on in the AM and take off in the evening. two [sic] times a day for leg bag." On 03/12/24, at 10:00 AM, Surveyors interviewed Administrator D and RD E via phone conference. When asked if Surveyors had the most current ISP for Resident 2, RD E stated the ISP may have been updated with a running record. Surveyors requested the most current ISP be sent via email during the phone call for review. RD E sent Resident 2's current ISP during the phone call. The ISP indicated the last service plan review was completed on 12/20/2023. It did not include information relating to Resident 2 being a high fall risk. It did not include instructions for staff on how to provide daily maintenance for the urinary catheter. When asked why the ISP had not been updated to include catheter care instructions for staff, Administrator D stated they would add more information to the ISP. Cross Reference N0431 DHS 83.38(1)(g) Health Monitoring N0386 DHS 83.35(3)(a) Comprehensive	N 389		

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N 389	Continued From page 24 Individualized Service Plan	N 389		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health 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 25 This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure Resident 1 and Resident 2 received appropriate health monitoring to meet their needs. Resident 1's skin was vulnerable and prone to bruising and tearing with daily ADL assistance from staff. Resident 1 sustained several bruises and skin tears that were not documented, monitored, or assessed by facility staff. Resident 2's daily catheter care needs were not accurately captured on the medical administration record (MAR) or Individualized Service Plan (ISP). The provider did not monitor fluid intake or urine output when Resident 2 was experiencing renal decline and had been diagnosed with a urinary tract infection (UTI). Findings include: On 01/16/2024, the department received a complaint alleging resident care needs were not being met by the provider. On 02/27/2024, Surveyors conducted an onsite visit and requested Resident 1 and Resident 2's records. Resident 1 Resident 1 had an admission date of 12/05/2022, and had the following diagnoses: Atrial fibrillation and flutter, vitamin B12 deficiency anemia, hypothyroidism, benign prostatic hyperplasia, intrinsic (allergic) eczema, legal blindness, dementia, anxiety, osteoarthritis, and unspecified macular degeneration.	N 431		

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N 431	Continued From page 26 On 02/27/2024, Surveyor requested Resident 1's most current ISP. The ISP received from the provider was dated and signed on 05/16/2023, and the following areas (related to skin) read, in part: -Wound Care: (This section was crossed out with a handwritten note that read, "remove. -healed 05/11/23). -Showers: [Resident 1] will receive physical assistance with bathing. Interventions: Shower chair owned by Resident. Staff will provide physical assistance during baths. Staff will notify nurse/physician with any changes in bathing abilities as necessary. Prefers: Shower. (A handwritten note dated 05/11/2023 read, "Hospice does showers 2xweek [sic]." -Skin: [Resident 1] will remain free from skin breakdown. Interventions- [Resident 1] has chronic eczema on [his/her] back, bruises easily, and obtains skin tears easily. [Resident 1] has history of recent skin tears to bilateral knees, and elbows. Staff will provide skin care as ordered by physician and listed on the eMAR (electronic medication administration record) and notify physician of any changes or concerns. On 02/27/2024 at 9:20 AM, Surveyor interviewed Caregiver J and Caregiver K about Resident 1's care needs related to skin. Caregiver J stated, "I remember when [s/he] got a skin tear on [his/her] arm and they (management) told us to bandage it up and send a secure message to [Administrator D]." Caregiver J informed Surveyor that the provider did not have a protocol in place for staff to monitor skin issues like bruising, and informed Surveyor that staff don't measure or assess bruises or chart on the progress or status of the	N 431		

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area. Caregiver J stated the secure messages were a communication tool used internally and was not sure if it was part of the record.

Caregiver K stated, "[S/he] was always agreeable. [His/her] skin was very thin, very red, was on a steroid for that. It tore easily and bruised easily." Caregiver K reported Resident 1 had several falls, some that were "assisted falls" (with a caregiver present) because s/he lost his/her balance with transfers. Caregiver K stated Resident 1 did not ambulate and was transferred with 1-assist with gait belt from walker to wheelchair. Caregiver K stated 2 falls occurred while getting out of bed due to "lack of strength to stand."

Caregiver J and Caregiver K reported staff charting was "very bare bones," and explained that staff don't chart in resident records, but only chart by marking "yes" or "no" for assigned tasks.

On 02/27/2024 at 11:30 AM, Surveyor interviewed Caregiver C via phone and asked about Resident 1's skin. Caregiver C stated Resident 1's skin was very thin and fragile and s/he remembered seeing his/her back bandaged up. Caregiver C stated, "You needed to treat [him/her] like a fragile egg. S/he would bruise easily if you weren't careful."

On 02/27/2024, Surveyor requested all documentation related to Resident 1's skin, including staff charting, progress notes and orders. RD E provided Surveyor with orders and limited progress notes. Surveyor reviewed 9 hospice notes and one physician order, dated 12/28/2023.

The hospice notes read, in part:

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N 431	Continued From page 28 -12/27/2023: Skin tear right wrist 1cm, cleansed, new dressing placed. Only should have Optifoam gentle dressings applied to skin tears. Has one healing skin tear right bicep area, 2 small abrasions on back, one skin tear right shin. Healed skin tears noted to right tricep, left bicep and top of left shin. Noted yeast to groin folds bilaterally. Clean groin twice daily, dry well and apply nystatin powder. Stinging to right wrist after changing skin tear dressing. Ibuprofen given during visit. Noted extensive bruising to right chest, upper arms. Hospice will visit and change all skin tear dressings every Monday, Wednesday and Friday. -12/21/2023: Assessed new skin tear to right bicep, large 2 inch, half moon shaped skin tear. Applied new soft bordered foam dressing. No signs of infection. Foam dressing changed to tricep area right arm, healing nicely, new foam dressing applied. Changed 3 foam dressings to right shin. Top 2 open areas are scabbed over and not open. Foam dressing applied for protection. Bottom skin tear on right leg is open 0.5 cm (centimeters) slight drainage of red drainage. Applied dressing. -12/11/2023: Skin tears to legs healing slowly. -12/04/2023: New skin tear to right knee. Dressing applied. -11/27/2023: Has a skin tear to right elbow, left knee and right shoulder blade. Dressing change done. Two-person assist working well. -11/17/2023: Using gold bond on back instead. Skin tear on back healed.	N 431		

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N 431	Continued From page 29 -11/10/2023: Skin tear healing to right upper back. -11/06/2023: Skin tear to right upper back from slide to floor over the weekend. New dressing applied. Increased weakness and fatigue. -10/18/2023: Skin tears healing to left leg. The physician order, dated 12/28/2023 read in part, "Continue monitoring [his/her] bruising-update us if any hematuria." HOSPICE INTERVIEW On 03/07/2024 at approximately 9:30 AM, Surveyor interviewed hospice Director of Nursing (DON) L via phone. Surveyor requested verification on the hospice charting notes received from the provider and asked if any additional notes were available regarding Resident 1's skin. DON L confirmed the following notes were available regarding Resident 1's skin, not maintained in the facility record: -12/26/23: New bruising, patient was asleep in recliner and patient's skin is paper thin is bruising all over has new purple bruising over right nipple and over chest, denied pain or injury. Coordinated with facility staff. Patient requires 2 person transfer due to weakness. -12/18/23: Requiring assistance with all ADLs (activities of daily living) except eating, 2-person transfer, had 2 falls in the last 2 months only able to stand for 1 min and legs get weak and has to sit, does not ambulate any longer, trunk control decreasing leans more to right in wheelchair and	N 431		

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recliner ...has pain and itching to back at times, gets gold bond menthol to back, no longer using cream, fragile skin, several abrasions over [his/her] body....

-12/15/23: [Resident 1] reports waking up in middle of night with back itchy and burning, staff applied gold bond lotion.

-12/08/23: 3 new abrasions, on aspirin, steroid injections every 3 months. Takes 2 people to transfer, not every day but noticeable.

-12/01/23: Bruising all over arms and legs. Requires assistance with 5/6 ADLs.

-11/24/23: Home health aide notified s/he has abrasion on right shoulder and bruising on back. No fluid surrounding area. Skin is fragile sensitive but no increased heat or redness. Call hospice if blister, redness, heat or fever develop over the weekend. Skin tear to right elbow healed... Coordinated care with facility.

-11/20/23: Laying [sic] in bed ready to get up, PCW (personal care worker) needing assistance getting up. Had a fall yesterday, did not get out of bed, right sided hip pain, able to transfer safely with gait belt and transfer to bathroom. Tired quickly was short of breath. Trialed sit-to-stand and unable to use. Sit to stand is not a safe option. 2-person assist with gait belt at all times. Administrator D aware. Skin tear to left elbow new dressing applied. Denied pain today. Using gold bond on skin.

11/19/23: Per report of staff patient was being transferred and legs were too weak and fell to floor. New skin tear to right elbow. Transfers with 2 staff only. Facility placed a new call button

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pendant on wrist and tested ability to push it successfully. Will start 30-minute patient rounds to check on him/her. 2nd fall in last month due to weakness.

-11/13/23: ...increased pain and itching to back. Gold bond effective. No pain or burning. 1+ pitting edema to lower extremities. Coordinated care with facility staff. Updated POA.

-11/04/23: After fall this morning per report of patient facility staff member was transferring him/her and slipped off edge onto the floor. No pain or sig (significant) injury but has small dime sized skin tear to back. Decreased strength. Resident stated, "Some would call that a fall but I slid off the edge of the bed." Denies injury or pain.

-10/23/23: ...bruising noted to arms and legs, scabbed areas to left knee, healing. Transfers with 1 person assist with gait belt. Will take him 2 people to assist to bed. Takes several attempts to get into standing position. Coordinated care with facility.

-10/20/23: ...Tramadol effective for pain control. 1+ pitting edema to lower extremity.

INTERVIEW

On 03/12/2024 at approximately 10:30 AM, Surveyor asked Administrator D and Regional Director (RD) E if the ISP received on 02/27/2024 was the most current ISP on file, as requested. Administrator D stated the ISP provided was a "significant change' ISP update and would get the most current ISP sent."

On 03/12/2024 at 10:42 AM, RD E emailed Surveyor Resident 1's ISP, with a date of

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N 431	Continued From page 32 02/27/2024 for the "last service plan review completed." The ISP sections related to skin read, in part: -Skin condition: Has chronic eczema on back, bruises easily, and obtains skin tears easily. Has history of recent skin tears to bilateral knees, and elbows. Staff to provide skin care as ordered by physician and listed on the e-MAR (electronic medication administration record) and notify physician of any changes or concerns. Likes eczema cream massaged into skin. -Bathing: Hospice completes all routine bathing. Shower chair owned by resident. Staff will provide physical assistance during bathing as needed. Family has provided shower sponges for all bathing. Staff will avoid using wash cloths on back and arms. On 03/12/2023 at approximately 10:00 AM, Surveyor interviewed Administrator D and RD E and discussed the concern that Resident 1's skin (prone to bruising and tearing) was not monitored by the facility and that several hospice notes regarding Resident 1's skin were not maintained by the provider in Resident 1's record. Administrator D informed Surveyor that hospice does not provide them with skin notations, and stated s/he was concerned that they (the provider) did not receive the same information hospice provided to the Surveyor. Administrator D reported the hospice agency should be communicating with the facility and stated, "[Resident 1]'s skin would have been monitored by hospice. [S/he] (Resident 1) would have exceeded our 3 hours of nursing just to monitor [his/her] skin. Family knew that." RD E confirmed staff were not monitoring Resident 1's skin, and	N 431		

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stated, "Hospice would own it (monitoring Resident 1's skin). Unless they gave us orders, that would be them owning that. Care staff would update hospice if they noticed something new but we don't typically monitor bruising, or skin tears..."

The provider did not ensure Resident 1's health was monitored when Resident 1's skin was vulnerable and prone to bruising and tearing with daily ADL assistance from staff. Resident 1 sustained several bruises and skin tears that were not documented, monitored, or assessed by facility staff. The provider placed responsibility on the hospice agency to monitor Resident 1's skin.

Resident 2
Resident 2 was admitted to the facility on 11/21/2023, with a urinary catheter and diagnoses of dementia, acute kidney injury and obstruction/lower urinary tract symptoms. Resident 2's pre-admission health assessment, dated 11/13/2023, identified s/he required assistance with catheter care and noted prostate concerns that included, "Resident not able to fully void - has failed voiding trials."

On 02/27/2024, at 9:20 AM, Surveyor observed Caregiver A administer Resident 2's 8:00 AM dose of medications. When asked which staff were able to complete catheter cares, Caregiver A stated anyone can do catheter care. After the medication pass was completed, Caregiver A asked Caregiver B to change Resident 2's catheter bag as it appeared full of urine.

At 9:32 AM, Caregiver B provided catheter care assistance to Resident 2. Caregiver B removed the overnight catheter bag and attached a leg catheter bag to Resident 2's leg. After the leg catheter bag was attached, Caregiver B placed

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the overnight catheter bag containing urine in Resident 2's bathroom. Caregiver B hung the catheter bag on a handrail next to the toilet. Caregiver B did not measure the urine output, pour out the urine, or clean the catheter bag.

At 11:35 AM, Surveyors interviewed Caregiver C. Caregiver C stated s/he would change Resident 2's catheter bag when s/he was the scheduled medication passer. Caregiver C stated there had been confusion expressed by staff about who should change the catheter bags and when the bags should be changed. When asked about Resident 2's catheter care needs, Caregiver C stated, "[S/he] was a mess yesterday." Caregiver C stated nobody was changing Resident 2's night catheter bag to his/her day catheter leg bag. Caregiver C stated there had been blood all over and staff called the home health care agency for assistance. Caregiver C stated catheter care tasks were not documented in the record and staff do not document fluid intake or urine output for Resident 2. When asked about staff training opportunities, Caregiver C stated s/he completed training with a medication passer.

At 1:09 PM, Surveyor returned to Resident 2's bathroom. The overnight catheter bag containing urine was hanging in the same position as previously observed earlier that morning. It did not appear to have been emptied or cleaned.

At approximately 1:47 PM, Surveyors interviewed RD E. When asked about catheter care tasks provided by staff, RD E stated staff were in charge of changing and cleaning the catheter bags. S/he stated that was usually completed by the scheduled medication passer on shift. RD E stated any care tasks for the medication passer should be on the MAR.

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N 431	Continued From page 35 On 03/04/2024, Surveyors requested additional documentation from Administrator D and RD E. On 03/05/2024, Administrator D provided additional documentation for review via email. Surveyor reviewed medical notes from February 2024 that included the following: -On 02/08/2024, progress note stated a family member had concerns of intermittent bloody urine and occasional clots in Resident 2's Foley (catheter) bag. The family member also stated concerns with Resident 2's concentrated urine. -On 02/09/2024, Resident 2 was admitted to the ER (emergency room) with diagnoses of Urinary Tract Infection (UTI) and mechanical complication of genitourinary device, implant, and graft. Medical notes indicated Resident 2's kidney function was lower than the previous reading documented. The notes emphasized the importance of Resident 2 maintaining hydration and increasing fluid intake. Patient education material was provided, including a document titled, "How to Care for Your Foley Catheter." The steps included the following, "Rinse your used, empty drainage bag with1 cup (240 mL) vinegar mixed with 1 cup (240 mL) water. Shake mixture around and allow to sit for about 15 minutes. Rinse thoroughly with cool water and allow to dry." Surveyor reviewed staff notes from December 2023 through February 2024 that included the following: -On 12/26/2023, "Resident was experiencing red/brown urine in catheter bag." -On 01/24/2024, "Request sent via fax to MD office for HHC (home health care) services for catheter care."	N 431		

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-On 02/09/2024, "Resident reporting pain to abdomen and care staff noting little output in Foley catheter. Sent to ER for follow up."

Surveyor reviewed home health agency notes from January 2024 and February 2024, that included the following:
-On 01/16/2024, stated Resident 2 was discharged from home health services. The note advised staff to follow up with urology and primary care provider for further catheter maintenance.
-On 02/12/2024, stated Resident 2 was enrolling with new home health agency. The note stated slight hematuria was observed in the urinary catheter bag during visit.
-On 02/15/2024, advised staff to continue with catheter cares twice daily. The note stated cares included cleansing the catheter bag and tubing connections with changes.
-On 02/16/2024, stated home health agency staff provided education to facility staff on signs and symptoms to monitor that included: complaints of dizziness, low blood pressure, elevated heart rate. The note advised staff to be using leg bags during the daytime to prevent trauma.
-On 02/22/2024, stated, "Has overnight bag on, reports gets [sic] some trauma with having this on, please schedule putting on leg bag in am [sic], change in evenings."

Resident 2's current ISP, dated 12/19/2023, included a section titled, "CATHETER." Under the goal section, it stated, "Home Health/Hospice will assist [Resident 2] with maintaining [his/her] catheter." Under the interventions section, it stated, "[Resident 2] receives assistance through Home Health to maintain ordering, refilling, and changing his/her catheter. Staff will provide assistance with catheter care as needed. Staff will notify Home Health Nurse/physician with

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changes in catheter as needed." The ISP did not contain information for staff on how to complete tasks associated with changing and cleaning Resident 2's urinary catheter bags.

Surveyors obtained a copy of the provider's catheter care policy and procedure. The document titled, "How to Care for & Empty Urinary Catheters" stated, "If you are measuring and recording your urine output, drain the urine into a clean measuring cup. If you do not need to measure your urine output, drain the urine into the toilet. After the urine has fully drained, wipe the drain spout and cap with an alcohol swab and put the stopper or clamp on." Caregiver B did not follow that procedure during the onsite observation.

Resident 2's December 2023 MAR and January 2024 MAR did not contain an order for catheter care tasks to be completed by facility staff. Resident 2's February 2024 MAR contained an order for catheter care with a start date of 02/27/2024 at 1900 hours, which was the evening of the day surveyors were on site. The order stated, "Foley Catheter Care should be completed during all three shifts, including peri/catheter care and emptying of catheter bag. three [sic] times a day for Maintenance [sic]." The March 2024 MAR included an additional order with a start date of 03/05/2024, that stated, "Put leg bag on in the AM and take off in the evening. two [sic] times a day for leg bag." Surveyor observed Caregiver B complete the catheter bag change prior to both of those orders being added to the MARs.

On 03/05/2024, at 4:00 PM, Surveyor interviewed Home Health Director (HHD) F. HHD F stated the home health agency began providing services for

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N 431	Continued From page 38 Resident 2 on 02/12/2024. HHD F stated a different agency had been providing services prior to Resident 2's enrollment. When asked how services had been going for Resident 2, HHD F stated they have had several problems with Resident 2's catheter since they started services. HHD F stated Resident 2 had a lot of malfunctioning catheter issues. S/he stated most of the time with catheter care patients, the home health agency does monthly visits. HHD F stated they visited the facility at least 6 times to provide catheter care assistance for Resident 2. HHD F stated that on 02/29/2024, home health agency staff arrived at 9:50 AM and Resident 2 still had his/her overnight catheter bag on. HHD F stated home health staff provided education to facility staff on the importance of changing the overnight catheter bag to a leg bag. HHD F stated the maintenance of Foley care and "daily stuff" should be done by the provider. HHD F stated the home health agency had recommended the provider implement a device that holds the tubing in place on Resident 2's leg. It was described as a sticky, circular piece of plastic, that would help prevent the catheter tubing from being pulled on. HHD F stated the provider had not implemented that consistently and that it is "sometimes on and sometimes off." On 03/05/2024, at 4:30 PM, Surveyor interviewed Resident 2's prior home health care agency and spoke with Home Health Agent) HHA G. HHA G stated services were provided for Resident 2 between 11/22/2023 and 01/16/2024. HHA G stated Resident 2 did not receive any services after the discharge date. HHA G stated Resident 2 received skilled nursing services once weekly for 2 weeks and the schedule must have changed to once every other week. HHA G counted a total of 6 visits were completed with Resident 2.	N 431		

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N 431	Continued From page 39 On 03/12/2024, at 10:00 AM, Surveyors interviewed Administrator D and RD E. Surveyors discussed the home health care agency's role in providing catheter care for Resident 2. When asked about Resident 2's enrollment with home health care, Administrator A stated Resident 2 had been "enrolled the entire time" but had switched between two different agencies. Surveyor discussed findings obtained through home health agency representative interviews that contradicted Administrator A's statement. Surveyors informed Administrator A and RD E it was determined Resident 2 did not have home health services for approximately 4 weeks. RD E stated there was a chance there was a gap in services between the two agencies. RD E stated catheters did not require daily intervention from the home health agency and those visits were typically scheduled once per month. RD E stated it was standard practice for facility staff to be emptying and cleaning the catheter bags during that time period. When asked if the provider monitors fluid intake or urine output for residents, RD E stated they do not. When asked to describe the process staff used to clean the catheters, RD E stated staff should be emptying the bags and using an alcohol swab to clean the cords connected to the catheter bag. RD E stated that if a resident was switching from an overnight bag to a leg bag, staff should have a bag prepped and cleaned. RD E stated staff would rinse the bag with vinegar solution to help with the smell and cleanliness. Surveyors discussed the provider's catheter care policy and procedure and concerns about the lack of clear instructions included in the policy. Surveyors discussed concerns with Caregiver B not following the catheter care procedures during Resident 2's catheter bag change. RD E stated Caregiver B should have	N 431		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 431	Continued From page 40 emptied the catheter bag and it was another point of education for staff. RD E stated Caregiver B no longer worked for the provider. Surveyors discussed the education material provided by the hospital following Resident 2's ER visit that indicated the use of vinegar solution for cleaning the catheter bags. RD E stated that was only a recommendation from the doctor and the use of vinegar solution was a family preference and not a requirement. RD E stated vinegar solution was not an infection control practice but was for the management of smell. RD E stated the provider did not provide vinegar solution and that would be purchased by the resident or family members if desired. Cross Reference N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan N0389 DHS 83.35(3)(d) Service Plans updated Annually or On Changes	N 431		
Y3100	50.09(1)(f) RESIDENT'S RIGHTS IN CERTAIN FACILITIES (2) The department, in establishing standards for nursing homes and community based residential facilities may establish, by rule, rights in addition to those specified in sub. (1) for residents in such facilities.	Y3100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019249	A. BUILDING: _____ B. WING _____	C 04/12/2024

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CAMBRIDGE SENIOR LIVING	3172 OLD TOWN ROAD EAU CLAIRE, WI 54701

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Y3100	Continued From page 41	Y3100		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure each resident's right to have private, unrestricted communications; and physical and emotional privacy in living arrangements was maintained. This had the potential to affect 57 of 57 residents that resided in the facility.

The facility had multiple electronic video surveillance cameras, including cameras located in 4 of the 4 bistros, seating areas/living rooms and entrance hallway.

Findings include:

This provider is licensed to care for up to 60 residents in the client groups of: advanced age, physically disabled, and irreversible dementia/Alzheimer's disease. The facility is 2 floors with the east and west wings mirroring each other on each floor. Each wing has a dining area, seating area/living room, and a bistro.

The Department's position on electronic video monitoring or filming in areas where residents may be seen or heard is viewed as infringing upon a resident's right to privacy and right to a living arrangement that is as homelike as possible.

On 02/27/2024 at approximately 8:50 AM, Surveyor toured the facility with Administrator A. Surveyor observed cameras at the entrances/exits of the facility, near the administrative offices and conference room, living

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Y3100	Continued From page 42 rooms in each wing, and in all 4 bistros located in the facility. The cameras in the bistros were located on the ceiling facing the cooking area where residents could pass through. There was nothing in place to deter access to the area. On 02/27/2024 at approximately 1:16 PM, Surveyor observed a resident seated in the east wing living room on the 1st floor. The living rooms were equipped with cameras. Administrator A informed Surveyor most of the cameras were not in use or "blacked out," but still physically up. On 02/27/2024 at approximately 1:06 PM, Surveyor observed a sign located across from the west wing living room, next to the door leading out to the patio. The sign read, "For the safety & security of our residents, guests, & staff members, cameras are in use on the premises. Thank you for your cooperation!" The provider did not ensure each resident's right to privacy was maintained when they installed electronic surveillance cameras in areas where residents may be seen or heard.	Y3100		