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N 000	Initial Comments On 01/29/2024, Surveyor conducted a complaint investigation at NEW Perspective West Bend. Additional information was obtained through 02/09/2024. The complaint was substantiated and resulted in 2 deficient practices. Census: 31	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not immediately take steps to protect the residents or conduct an investigation when local police reported potential abuse and/or neglect of Resident 1 to the	N 158		

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

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N 158	Continued From page 1 provider. Findings include: On 01/17/2024, the department received a complaint alleging residents were found in a state of distress and potential neglect by the local emergency services. On 01/30/2024, Surveyor reviewed Resident 1's records and noted Resident 1 was admitted on 08/31/2023 with an activated Power of Attorney (POA H). Resident 1's diagnoses included: Type 2 diabetes mellitus with hypoglycemia, chronic atrial fibrillation, chronic indwelling supra pubic foley catheter, pyoderma gangrenosum, hypertension, iron deficiency anemia, mixed irritable bowel syndrome, lymphadenitis, urogenital implants, hemorrhoids, depression, unspecified pain, muscle weakness, benign neoplasm of colon, rectum, anus and anal canal, multiple fractures of ribs (left side,) vascular dementia, other behavioral disturbances, abnormalities of gait and mobility, cognitive communication deficit, cutaneous abscess, and Urinary Tract Infection (UTI.) On 01/29/2024, Surveyor reviewed the police report written by Officer A regarding a medical call investigation conducted on 01/12/2024: "On January 12th, 2024, at about 0300 hours, [Officer A] was dispatched to New Perspective Senior Living ... for the report of [Resident 1] bleeding from [his/her] [genitals] and feeling sick. The [caller] provided the name of [Resident 1] ... While enroute, dispatch advised them [Resident 1] seemed confused ...	N 158		

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N 158	Continued From page 2 [Officer A] arrived on scene along with the West Bend Fire Department at about 0307 hours. [Officer A] walked to the main entrance and found the second sliding door to be locked, they rang the doorbell, but no one came to the door. [Officer A] walked to where [Fire Fighter B and C] were, which was the door to the memory care unit (Betty's Harbor). The first door was not locked, but the second set of doors were locked. They rang the doorbell but received no answer. [Officer A] called the phone number listed on a form near the doorbell ... which was the business line for New Perspective. [Officer A] was given three different prompts and used each of them. All three prompts did not yield them to speaking with someone, rather allowed them to leave a voicemail. Shortly after, [Fire Fighter B] was able to override the security door to the memory care unit and gain access. Access was gained to the unit at about 0312 hours. Due to the security door being overrode, an alarm system went off over the public address system. The alarm consisted of loud beeping and a voice saying "door two" indicating which door it was coming from. They located [Resident 1's] room at about 0313 hours. [Resident 1's] door was open, but [s/he] was not inside. The lights in the room were on and it smelled highly of fecal matter. At about 0314 hours, [Fire Fighter C] located [Resident 1] walking in the halls, crying for help. [Resident 1] appeared very distraught saying 'no one is here' and 'I went through the whole building.' It should be noted, the memory care unit is laid out in one large circle with rooms on the outer. [Resident 1] was walking with a walker and wearing what appeared to be a night gown.	N 158		

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N 158	Continued From page 3 [Resident 1] also smelled of fecal matter and his/her catheter tube could be seen hanging from [his/her] pubic region. [Resident 1] stated [s/he] called 911, as [s/he] was in pain and thought [s/he] was bleeding from [his/her] [genitals.] [Resident 1] was assisted onto the rescue cot and evaluated by [Fire Fighter B and C.] Due to no staff members being located, they took [Resident 1] out to the ambulance and obtained a set of vitals on [him/her] at about 0321 hours. [Resident 1] was later transported to Froedtert West Bend for further evaluation. [Officer A] remained on scene in hopes to locate a staff member, due to no staff not being located from the time we arrived on scene, 0307 hours, and the time [Resident 1] was placed in the ambulance, 0321 hours. During that time, the door alarm was going off and could be very easily heard. At about 0323 hours, [Officer A] made phone contact with [Keyholder D,] as [s/he] was listed on [sic] the keyholder listed. [Keyholder D] was briefed on the staff concerns and [Keyholder D] stated there should have been three staff members working, one in the New Perspective side and two in the memory care unit. [Keyholder D] stated [s/he] would contact another employee and have said employee contact [Officer A] back. [Officer A] began walking around both sides of the building searching for a staff member, but still could not locate one. [Officer A] received another phone call back from [Keyholder D] at about 0331 hours stating the [Executive Director E] would be contact [sic] [Officer A] shortly regarding the issue.	N 158		

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[Officer A] then returned to the 1st floor and located [Caregiver F], where both sides of the building are divided into their respective units, at about 0330 hours. [Officer A] asked [Caregiver F] what was going on and they stated they did not know, but [Caregiver F and G] were in another resident's room, changing them, which required two people to do. Both staff members did not know [Resident 1] called 911, or that [s/he] was transported to the hospital via ambulance. Both stated the doorbells were loud, but because the door alarm was going off, they could not hear it. [Officer A] asked what their procedure was for when the door alarms went off. [Caregiver F] stated to turn the alarm off. [Caregiver F] was told [Resident 1] was found walking around the memory care unit calling for help.

[Caregiver F] stated being familiar with [Resident 1,] as [s/he] dealt with severe internal pain. Neither [Caregiver F], nor [Caregiver G] had much information on why it took so long for a staff member to be located besides they were changing another resident.

Phone contact was made with [Executive Director E], while speaking with [Caregiver F and G.] [Executive Director E] was informed of the reason for the contact. [Executive Director E] seemed very displeased that it took so long for staff to be located and that they had no idea [Resident 1] left the facility via ambulance. [Executive Director E] stated [s/he] would speak with both [Caregiver F and G] regarding the issue, and likely retrain them.

[Officer A] responded to Froedtert West Bend to speak with Resident 1 regarding the time frame of his/her pain/reason for calling 911. Resident 1 reported having pain internally and thought [s/he]

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N 158	Continued From page 5 was bleeding from [his/her] [genitals.] [Resident 1] stated [s/he] did not have a call button in [his/her] room. [Officer A] asked how [Resident 1] got in contact with staff if [s/he] needed help and [s/he] stated [s/he] typically walked around looking for help. [Resident 1] stated today, [s/he] remembered calling 911 and then walking around the memory care unit looking for help but was never able to find anyone. [Resident 1] stated [s/he] felt no one was working at the time ..." On 01/29/2024, Surveyor conducted an interview with Executive Director E and Wellness Director I at approximately 11:30 AM. Executive Director E stated s/he was contacted by Keyholder D to call Officer A on 01/12/2024 at approximately 3:30 AM. Executive Director E confirmed when s/he spoke with Officer A at approximately 0335 AM Officer A discussed the circumstances that lead to their involvement and Resident 1 being transported to the hospital. Executive Director A confirmed s/he was notified about the state in which Resident 1 was found and the concerns regarding staff not being able to be located. Executive Director A confirmed s/he told the officer the staff would be talked to and the situation would be looked into by the provider. Executive Director A stated s/he reached out to his/her team via e-mail on 01/12/2023 at 4:15 AM: "[Keyholder D] received a call from a police officer around 320 this morning who is trying to get in touch with somebody at the community as they could not find any caregivers. [Keyholder D] called me and I tried to get on Notify, call the community, and even texted [Caregiver G's] personal phone directly with no response from any for over 20 minutes.	N 158		

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In the meantime, I called the officer back to figure out what was happening and [s/he] stated that they got a 911 call from [Resident 1] and were coming to investigate. They arrived just after 3am. They could not get into the community after calling and ringing the doorbell and could not find a caregiver from the outside so they set off the door alarms. They said it took 30 to 40 minutes to finally get a caregiver. The officer even walked the halls of BH [sic] and noticed [Resident 1] walking around crying.

When they did find the caregivers [Caregiver F and G,] they asked if they heard the door alarms which they responded yes, but they were changing a two person assist, so didn't answer it. After I took down the officers report, [Caregiver G] texted me back and I confirmed that they have the caregiver phones on them (or so they said). I then got a message back on Notify from [Caregiver F] and [Caregiver J.]

[Keyholder D] is putting in an IT ticket to see the timeline that the alarms went off without being checked. We really need to emphasize the importance of the door alarms, and what to do when they go off. I understand that they were changing somebody at the time, but a sounding door alarm at such an odd hour, should really take precedence and be checked timely. I will escalate this up, but I believe this will fall under a state reportable due to police intervention ..."

Executive Director E stated s/he had intentions to "elevate" the situation to be looked into further but ultimately did not. Executive Director E stated the next day there was a snowstorm and s/he forgot to submit a self-report to the state. Upon review of the code and situation where Officer A described the resident was found in distress,

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without caregiver assistance, and complaining of pain and bleeding from his/her genitals, Executive Director E acknowledged the verbal report was an allegation of neglect and/or abuse. Executive Director E stated s/he was aware the situation was reportable as a self-report due to police intervention but did not recognize the situation as possible neglect and/ or abuse until after discussing it during the interview with Surveyor. Executive Director A stated, "I take full responsibility for not reporting or completing an investigation."

Executive Director E stated s/he had not reached out to receive a copy of the police report. Executive Director E stated s/he believed s/he spoke with and/or texted Caregivers F and G on 01/12/2024 after the incident. When asked to provide the time from his/her phone log of when the calls and or text were made s/he stated s/he could not say as s/he didn't have the information on his/her phone. Upon further interview neither Executive Director E nor Wellness Director I could provide answers regarding the events that lead to not being able to find a caregiver for approximately 30-40 minutes or actions taken after the provider was notified. Executive Director E then stated s/he delegated speaking with Caregivers F and G and providing reeducation to their direct supervisor, Care Team Manager K. Surveyor asked for all records regarding the incident including any investigation, statements, pertinent employee files and/or education to be sent.

On 01/30/2024, Surveyor received an e-mail from Executive Director E at 9:57 AM:

" ...After meeting with my care team manager, we unfortunately do not have documentation of

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meeting with the two team members (Caregiver F and G).

I am attaching the email that I had sent out that morning, indicating our next steps, it just was unfortunately not followed up and documented. I am working on the state report now, and will submit late."

On 01/30/2024 at 11:25 AM Surveyor interviewed POA H. POA H stated s/he received a call from the hospital staff in the early morning hours of 01/12/2023 notifying him/her that Resident 1 was in the emergency Department. POA H stated this was unusual as normally s/he would hear from the provider first to ask for his/her approval prior to sending the resident out for emergency services. POA H stated s/he was concerned as s/he had not received a call from the provider with a notification or update, so POA H called the provider at approximately 9:00 AM on 01/12/2024. POA H stated s/he spoke with Wellness Director I (confirmed by Wellness Director I in an e-mail on 01/31/2024 1 :54 PM.) POA H stated s/he was informed Resident 1 had been to the hospital after s/he called 911 to have his/her urinary catheter replaced and was going to receive treatment for a UTI. POA H had not been informed of the police and emergency services involvement, that there was a police report with concerns regarding neglect and/ or abuse, was not aware caregivers could not be located for 30-40 minutes or the state Resident 1 was reported to be found in by the police. POA H stated it was his/her right and expectation to be fully informed of the circumstances and s/he expressed being upset about the provider omitting pertinent information.

On 01/30/2024, Surveyor interviewed Manager K

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at 11:33 AM. Manager K stated s/he spoke with Caregiver G shortly before the interview on 01/30/2024 and asked Caregiver G what occurred. The account given to Manager K by Caregiver G did not match with the timeline or interviews in the police report. Manager K acknowledged there was not documentation of a meeting with the caregivers as s/he did not speak with Caregiver F and G after the incident, did not update the employee files, or provide education to the caregivers. Manager K stated s/he only spoke to Caregiver G briefly this morning on 01/30/2024. Manager K stated there had been a snowstorm the following day and s/he forgot to follow up with the staff.

On 01/30/2024, Surveyor interviewed Caregiver G at 12:02 PM. Caregiver G stated s/he and Caregiver F were located in the CBRF during the overnight shift into the morning of 01/12/2024. Caregiver G stated no administrator followed up with him/her after the event, no statements were taken, and no education had been received.

On 01/30/2024 at approximately 12:15 PM, Surveyor interviewed Executive Director E. During review of the conflicting timeline and events from the reports and interviews Executive Director E stated the incident occurred "a while ago" and s/he didn't expect the caregivers to remember the details. Executive Director E acknowledged the incident occurred only 17 days prior the beginning of the survey, was significant enough that both the police and fire departments were involved, and had two caregivers present to recall events. Executive Director E acknowledged the importance of conducting an immediate investigation as is required by the code to obtain investigative information timely. Executive Director E stated s/he was unaware Manager K

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did not follow up with the caregivers. Executive Director E stated s/he was working on a self-report to be submitted late to the state regarding the incident. Executive Director E questioned if an investigation still needed to be completed regarding the allegations for neglect/ and or abuse. The discrepancies between the police report and caregivers account of what occurred on 01/12/2024 were reviewed. Executive Director E acknowledged although s/he was self-reporting the situation occurred the code requires all allegations of abuse or neglect to be investigated. Executive Director E acknowledged need to conduct an investigation and follow up with unanswered and/ or conflicting statements to make a final determination of if neglect or abuse occurred and if subsequent reporting to the Office of Caregiver Quality is required. Executive Director E stated s/he would send Surveyor the self-report and investigation once completed.

On 01/30/2024 at 1:46 PM, Surveyor received an e-mail from Executive Director E with a late self-report submission. The Self report included only the flowing information:

"Executive Director received a call from a police officer who was at the Community in response to a 911 call by Resident, who resides in memory care requesting assistance.

Incident outcome
Resident was transferred to the hospital emergency department for evaluation. Resident was found to have a UTI and returned to the community around 9am that morning with orders for an antibiotic.
Action Taken to Ensure Resident's Health, Safety, and Well-Being

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Resident was transferred to the hospital emergency department for evaluation. Resident's PCP and legal representative notified of incident/transfer to hospital. Resident returned to the community with new order for antibiotic. Community nurse faxed order to pharmacy and updated home health care nurse on UTI."

The self report is misleading and not inclusive of all elements that are required to be reported. The submission was noted under reason for report as "police on site" with no mention of neglect/ abuse allegations or concerns. The self-report did not address the lack of staff presence leading to lack of prompt care and treatment, the resident's pain and distress, the timeline of events, the fact the POA had to call to get an update that was not inclusive of the entire event and concerns, or address interventions for the omitted concerns and allegations.

On 01/30/2024, Surveyor received an e-mail from Executive Director E at 2:25 PM with Caregiver G's statement:

"[Caregiver G]: Verbal Statement was taken 1/30/24.
[Caregiver G] recalls that a phone call came in at 3:30am to caregiver phone, [s/he] stated it was the officer. [Caregiver G] stated [s/he] did not see any EMTs after leaving a resident's room after rounds (thinks it was in the middle area of the community, but does not recall which resident exactly), [sic] [Caregiver G] didn't notice any EMTs, but did hear the overhead alarm.
[Caregiver G] stated that [Caregiver F] then saw the officer and went to talk to [him/her] and [Caregiver G] attempted to turn off alarms."

The statement did not address the concerns

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related to investigating if abuse and or neglect occurred. The statement does not comment on the last time the resident was seen by the caregivers to establish a timeline, the state the resident was found in by the emergency team, resident's statements about bleeding from his/her genitals, or concerns related to why the resident wasn't being cared for by the staff.

On 02/09/2024 Surveyor reached out to Executive Director E via phone interview at approximately 10:00 AM. Executive Director E stated s/he thought Surveyor received Caregiver F's interview from Wellness Director I and acknowledged s/he had not completed a summary of his/her investigation. Executive Director E stated the investigation was for internal records and Surveyor was not allowed to review. Surveyor reviewed the provider had not recognized the need for an investigation until it was brought to their attention during the survey process as a requirement to investigate per the codes. Surveyor requested no internal documentation, but documentation to show an investigation was conducted and the resulting conclusion. Executive Director E stated s/he came to the conclusion no abuse or neglect occurred, despite multiple emergency personnel observing the caregivers were not present, because the caregivers "said they were there." Surveyor requested the investigation record with final determination be sent by 02/09/2024.

At 11:23 AM Surveyor received Caregiver F's statement from Wellness Director I:
"[Caregiver F]: Verbal Statement on 1/30/24

During third shift, [Resident 1] was walking around memory care visibly upset stating that [his/her] stomach hurt. On second shift, earlier

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that night, [Resident 1] had thrown up and had diarrhea. We called triage on the second shift, and they said to encourage fluids because [Resident 1] had done this in the past. At around 0245, [Caregiver G] and I started doing rounds. At approximately 0330, [Caregiver G] and I were walking out [Resident 2's room.] When [sic] I walked toward the dining room, I heard a door alarm start to go off. I heard an overhead alarm that door one had been opened. When I went to check it out, I saw a police officer pushing on the door that led to AL. The officer exited MC and was walking toward AL. I followed [him/her] into AL. [S/he] asked me a couple of questions and let me know that [Resident 1] had left the building and was going to the ER. I returned to Betty's Harbor after the police officer was done talking to me."

Caregiver F's statement notes the caregivers were aware Resident 1 had a change in condition on 2nd shift including episodes of emesis and diarrhea that would nessecitate health monitoring. Caregiver F additionally acknowledges s/he was aware Resident 1 had been walking around memory care on the 3rd shift while being visibly upset and expressing abdominal pain. The POA was not contacted. Per record review, no PRN pain medication was given. Caregiver F stated both caregivers were "doing rounds" for 45 minutes during the time they were aware the resident was upset, in pain, and needed health monitoring for his/her change in condition. The statement does not address the discrepancy of how the caregivers did not hear the alarms sounding until 3:30 AM if they were on the floor doing rounds where the alarms were observed to be clearly heard.

On 02/09/2024 Surveyor reached out to Wellness

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N 158	Continued From page 14 Director I and Executive Director E 12:15 PM via e-mail: "... Thank you for sending me the additional caregiver statement. I reached out to [Executive Director E] this morning and asked for the rest of the investigation/ summary to be sent by today as well ..." No additional information was provided to Surveyor as of 02/09/2024. On 01/12/2024, the provider did not have staff present to promptly meet the resident needs. Resident 1 was in pain and believed s/he was bleeding from his/her genitals, when s/he could not locate a caregiver and subsequently called 911 for help. The resident was found by emergency staff to be alone, distressed and in pain. Caregivers were aware Resident 1 was experiencing a change in condition and did not provide the monitoring s/he required or provide PRN pain management. The caregivers did not immediately respond to the alarms and their time and place could not be accounted for for greater than 30-40 minutes. The provider was informed of the concerns by local authorities, did not identify the situation as a potential for neglect and/or abuse, and did not take steps to immediately protect the residents. The provider did not investigate the allegations, did not follow up with staff as reported they would do to the police, and did not submit a self-report to the department. After the survey process made clear the event had the potential for neglect and/or abuse, the provider questioned if they still needed to complete an investigation after submitting a late self-report that omitted critical details and made no determination of the allegations of neglect and/ or abuse. The provider alleged the	N 158		

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N 158	Continued From page 15 investigation they were alerted they needed to complete by the survey process was now an internal investigation and did not provide the documentation to show an investigation and determination was conducted after the fact. As of 02/09/2024, no additional documentation has been received from the provider. Cross Reference N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs	N 158		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure enough caregivers were present to meet resident needs at all times. Local emergency services were called to the facility by Resident 1 when s/he could not find staff. Upon their arrival they found the resident in distress and could not locate a caregiver in the facility until after Resident 1 was transported to the hospital, approximately 30-40 minutes after their arrival. Findings include: The facility is licensed to care for up to 60 residents who may be advanced in age or have irreversible dementia/ Alzheimer's disease. On 01/17/2024, the department received a complaint alleging Resident 1 was found in a	N 396		

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state of distress by the local emergency services after calling 911 due to not being able to find a caregiver.

On 01/29/2024, Surveyor conducted an investigation including a tour of the facility accompanied by Wellness Director I at approximately 11:15 AM. Surveyor observed the main entrance of the facility had double glass doors, the first leading to a small vestibule area before a second glass door that led to the main lobby area of the attached Residential Care Apartment Complex (RCAC.) Surveyor noted an internal secured door leading to the Community Based Residential Facility (CBRF) that attends to resident with memory care needs. Wellness Director I referred to the internal door as "Door 1." Surveyor located a set of glass doors within the secured memory care CBRF that lead to the front parking lot. Wellness Director I identified the entrance as the door the firefighters gained access to the CBRF called "Door 2." Door 2 was a delay egressed glass door that led into a small vestibule before encountering another glass s door that is unlocked leading directly to the outside. When the internal egressed glass door for entrance 2 is engaged, Surveyor observed it had a loud beeping alarm and voiceover alerting "Door 2!" Surveyor observed during the activity hour it may be difficult to hear the alarm from across the CBRF if assisting in a resident room, but the alarm could be heard through the hallways and would be clearly heard during quiet hours of the night. Wellness Director I explained in addition to the overhead alarm, the caregivers carried cellular phones that were linked to the call light system and would alert the caregivers if a call light or alarm was going off. Wellness Director I stated there was 1 "red phone" that was linked to any outside callers and was given to the

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N 396	Continued From page 17 medication passer on each shift to take calls. On 01/29/2024, Surveyor conducted an interview with Executive Director E and Wellness Director I at approximately 11:40 AM. Executive Director E reviewed the staffing schedule and stated the overnight shift would "ideally" be staffed by at least 2 caregivers on both the RCAC and CBRF sides of the building. Executive Director E stated there usually would be 2 caregivers on the CBRF side and 1 caregiver on the RCAC side. Executive Director E stated there was at least one tenant in the RCAC that required the assist of 2 caregivers and confirmed when the tenant needed assistance it was expected that one caregiver would leave the CBRF to assist in the RCAC. Executive Director E and Wellness Director I identified 12 residents in the CBRF that required a 2 assist. After review of the code requirements to have enough staff present to meet resident needs at all times, Executive Director E and Wellness Director I acknowledged by requiring a caregiver assist in the RCAC the CBRF would be left with only 1 caregiver which would not be able to meet resident needs. Additionally, Executive Director E and Wellness Director I acknowledged during NOC shift, when 2 caregivers were in the CBRF and were required to assist with one of the 12 resident who need a 2 assist, no staff was present to supervise or assist other residents if needed. Executive Director I stated, "Even with 2 caregivers on the floor, if they are both busy in a resident room helping, there isn't anyone watching the other residents ... I mean clearly they didn't respond to the alarms or even know [Resident 1] was gone." Executive Director E stated on 01/12/2024 the amount of staff present had not been enough to meet Resident 1's needs. Executive Director E and	N 396		

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Wellness Director I expressed concern for their ability to adequately staff the facility to meet resident supervision and safety needs.

Surveyor reviewed the schedule for January 2024 and noted the CBRF and RCAC schedules were documented together showing 2 places for caregivers on the over night shift for each licensed area. The record shows on January 1, 2, 5, 6, 7, 10, 11, 12, 15, 18, 20, 21, 22, 23, 25, 29, 30, and 31of 2024, 3 caregivers were present between the 2 licensed facilities which required a caregiver from the CBRF to leave to assist in the RCAC when needed, resulting in only 1 caregiver available at times in the CBRF where 12 residents required 2 assist. Additionally Executive Director E confirmed in an e-mail (dated 02/09/2024 at 12:36 PM,) on January 27 and 28 only 1 caregiver was scheduled to be in the CBRF while only 1 caregiver was scheduled to be in the RCAC. 1 caregiver present is not adequate to meet the needs of the 12 residents who require 2 assists, or to provide adequate supervision to all 31 residents with memory care needs when assisting with cares. Additionally the caregivers are expected to assist with cares in the RCAC which has the potential of leaving the facility unattended.

On 01/30/2024, Surveyor reviewed Resident 1's records and noted Resident 1 was admitted on 08/31/2023 with an activated Power of Attorney (POA H) Resident 1's diagnoses include: Type 2 diabetes mellitus with hypoglycemia, chronic atrial fibrillation, chronic indwelling supra pubic foley catheter, pyoderma gangrenosum, hypertension, iron deficiency anemia, mixed irritable bowel syndrome, lymphadenitis, urogenital implants, hemorrhoids, depression, unspecified pain, muscle weakness, benign neoplasm of colon,

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rectum, anus and anal canal, multiple fractures of ribs (left side,) vascular dementia, other behavioral disturbances, abnormalities of gait and mobility, cognitive communication deficit, cutaneous abscess, and Urinary Tract Infection (UTI.)

On 01/29/2024, Surveyor reviewed the police report written by Officer A regarding a medical call investigation conducted on 01/12/2024. The reported noted the police responded to the emergency and sent the resident to the hospital via ambulance all while no caregiver could be located for over 30 minutes as the alarms were sounding.

On 01/29/2024, Surveyor conducted an interview with Executive Director E and Wellness Director I at approximately 11:30 AM. Executive Director E stated s/he was contacted by Keyholder D to call Officer A on 01/12/2024 at approximately 3:30 AM. Executive Director E confirmed when s/he spoke with Officer A at approximately 0335 AM Officer A discussed the circumstances that lead to their involvement and Resident 1 being transported to the hospital. Executive Director A confirmed s/he was notified about the state in which Resident 1 was found and the concerns regarding staff not being able to be located. Executive Director A confirmed s/he told the officer the staff would be talked to and the situation would be looked into by the provider. Executive Director A stated s/he reached out to his/her team via e-mail on 01/12/2023 at 4:15 AM:

"[Keyholder D] received a call from a police officer around 320 this morning who is trying to get in touch with somebody at the community as they could not find any caregivers. [Keyholder D]

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called me and I tried to get on Notify, call the community, and even texted [Caregiver G's] personal phone directly with no response from any for over 20 minutes.

In the meantime, I called the officer back to figure out what was happening and [s/he] stated that they got a 911 call from [Resident 1] and were coming to investigate. They arrived just after 3am. They could not get into the community after calling and ringing the doorbell and could not find a caregiver from the outside so they set off the door alarms. They said it took 30 to 40 minutes to finally get a caregiver. The officer even walked the halls of BH [sic] and noticed [Resident 1] walking around crying.

When they did find the caregivers [Caregiver F and G,] they asked if they heard the door alarms which they responded yes, but they were changing a two person assist, so didn't answer it. After I took down the officers report, [Caregiver G] texted me back and I confirmed that they have the caregiver phones on them (or so they said). I then got a message back on Notify from [Caregiver F] and [Caregiver J.]

[Keyholder D] is putting in an IT ticket to see the timeline that the alarms went off without being checked. We really need to emphasize the importance of the door alarms, and what to do when they go off. I understand that they were changing somebody at the time, but a sounding door alarm at such an odd hour, should really take precedence and be checked timely. I will escalate this up, but I believe this will fall under a state reportable due to police intervention ..."

Executive Director E stated s/he had not reached out to receive a copy of the police report.

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N 396	Continued From page 21 Executive Director E stated s/he believed s/he spoke with and/or texted Caregivers F and G on 01/12/2024 after the incident. When asked to provide the time from his/her phone log of when the calls and or text were made s/he stated s/he could not say as s/he didn't have the information on his/her phone. Executive Director E stated s/he did not have results from the IT request for room call times submitted by Keyholder D that was noted in his/her e-mail on 01/12/2024. Upon further interview, neither Executive Director E nor Wellness Director I could provide answers regarding the events that lead to not being able to find a caregiver for approximately 30-40 minutes. On 01/30/2024 at 11:25 AM Surveyor interviewed POA H. POA H stated s/he received a call from the hospital staff in the early morning hours of 01/12/2023 notifying him/her that Resident 1 was in the emergency Department. POA H stated this was unusual as normally s/he would hear from the provider first to ask for his/her approval prior to sending the resident out for emergency services. POA H stated s/he was concerned as s/he had not received a call from the provider with a notification or update, so POA H called the provider at approximately 9:00 AM on 01/12/2024. POA H stated s/he spoke with Wellness Director I (confirmed by Wellness Director I in an e-mail on 01/31/2024 1:54 PM.) POA H stated s/he was informed Resident 1 had been to the hospital after s/he called 911 to have his/her urinary catheter replaced and was going to receive treatment for a UTI. POA H had not been informed of the police and emergency services involvement, that there was a police report with concerns regarding neglect and/ or abuse, was not aware caregivers could not be located for 30-40 minutes or the state Resident 1 was reported to be found in by the police. POA H	N 396		

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stated it was his/her right and expectation to be fully informed of the circumstances and s/he expressed being upset about the provider omitting pertinent information.

On 01/30/2024, Surveyor interviewed Manager K at 11:33 AM. Manager K stated s/he spoke with Caregiver G shortly before the interview on 01/30/2024 and asked Caregiver G what occurred. The account given to Manager K by Caregiver G did not match with the timeline or interviews in the police report.

On 01/30/2024, Surveyor interviewed Caregiver G at 12:02 PM. Caregiver G stated there were usually 2 caregivers in the CBRF for overnight shifts and confirmed they were expected to leave the facility to assist with residents in the RCAC when needed. Caregiver G stated 1 caregiver would stay in the CBRF and acknowledged if a resident required a 2 assist, they would have to wait for the second caregiver to return from the RCAC. Caregiver G stated if both caregivers in the CBRF were assisting a resident who required a 2 assist in their room, they would not have a way to know if another resident was in need of assistance. Caregiver G stated if a call light went off it would notify them on their phones but the "call light system was down" the night of 01/12/2024 and they had no way to know if a resident needed assistance until they did rounds.

Caregiver G stated s/he and Caregiver F were located in the CBRF during the overnight shift into the morning of 01/12/2024. Caregiver G stated, "the call light system and alarm system was down and there was only one phone that worked. "Caregiver G stated they placed the red phone that "worked" in the center living room area. Caregiver G stated the caregivers were rounding

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N 396	Continued From page 23 the halls doing checks on resident when they heard the alarm and immediately ran to see what was happening. Caregiver G stated s/he tried to get the door to stop alarming while Caregiver F spoke with the police officer. Caregiver G stated there was only 1 police officer, and they were unaware Resident 1 had been transported to the hospital. Caregiver G stated the door alarms and doorbells were loud and could be heard throughout the memory care facility. When asked about the police report that the doorbell was rang multiple times at 3:07 while the emergency team was attempting to gain access to the facility and the overhead alarms were engaged at 3:12 via door 2's when the egressed door was opened by fire and rescue, Caregiver G had no explanation for why neither Caregiver G or F heard the alarms. Caregiver G reiterated they were doing rounds in the hallways and stated they were not caring for a resident with a need for a 2 assist at the time prior to or during when they heard the alarms. Surveyor reviewed the timeline noting when the first doorbell rang at 3:07 AM, the overhead alarms were engaged at 3:12 AM, the resident sent out to the hospital at 3:21 AM, the officer stayed to find a caregiver at approximately 3:30 AM and Caregiver G noting when they heard the alarm and found the officer it was after the resident was no longer at the facility. Caregiver G could not explain the time discrepancy, how the staff could have been walking the halls and not heard the alarms until after the resident was transported out of the facility, or why their statement to the police was that they had been caring for a resident who required a 2 assist when now stating they were not and had been doing rounds in the hallways. Caregiver G stated no administrator followed up with him/her after the event, no statements were taken, and no education had been received.	N 396		

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N 396	Continued From page 24 Surveyor interviewed Executive Director E on 01/30/2024 at approximately 12:15 PM. During review of the conflicting timeline and events from the reports and interviews, Executive Director E stated the incident occurred "a while ago" and s/he didn't expect the caregivers to remember the details. Executive Director E acknowledged the incident occurred only 17 days prior the beginning of the survey, was significant enough that both the police and fire departments were involved and had 2 caregivers present to recall events. Executive Director E acknowledged the information given that did not match was not just details but it could not account for over 30-40 +minutes of time where staff could not be located, was in direct conflict of when the alarms were sounding versus when the caregivers heard the alarms, and Caregiver F gave a different account of their whereabouts than Caregiver G during the timeframe they were unable to be located. Executive Director E stated s/he was unaware Manager K did not follow up with the caregivers. On 01/30/2024 at 1:46 PM Surveyor received an e-mail from Executive Director E with a late self-report submission. The Self report included only the flowing information: "Executive Director received a call from a police officer who was at the Community in response to a 911 call by Resident, who resides in memory care requesting assistance. Incident outcome Resident was transferred to the hospital emergency department for evaluation. Resident was found to have a UTI and returned to the community around 9am that morning with orders for an antibiotic.	N 396		

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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
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Action Taken to Ensure Resident's Health, Safety, and Well-Being

Resident was transferred to the hospital emergency department for evaluation. Resident's PCP and legal representative notified of incident/transfer to hospital. Resident returned to the community with new order for antibiotic. Community nurse faxed order to pharmacy and updated home health care nurse on UTI."

The submission was noted under reason for report as "police on site" with no mention of the lack of staff presence, the resident's pain and distress, or the timeline of events.

On 01/30/2024, Surveyor received an e-mail from Executive Director E at 2:25 PM with Caregiver G's statement:

"[Caregiver G]: Verbal Statement was taken 1/30/24.
[Caregiver G] recalls that a phone call came in at 3:30am to caregiver phone, [s/he] stated it was the officer. [Caregiver G] stated [s/he] did not see any EMTs after leaving a resident's room after rounds (thinks it was in the middle area of the community, but does not recall which resident exactly), [sic] [Caregiver G] didn't notice any EMTs, but did hear the overhead alarm. [Caregiver G] stated that [Caregiver F] then saw the officer and went to talk to [him/her] and [Caregiver G] attempted to turn off alarms."

The statement did not address the discrepancies of where the caregivers were from the unknown time Resident 1 began looking for caregivers to deciding to call 911 at 3:00 PM through 3:30 AM, when the doorbells began sounding at 3:07 AM and alarms beginning to sound at 3:12 AM, why

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013625	A. BUILDING: _____ B. WING _____	C 02/09/2024

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they had not heard them until 3:30, or why his/her statement varies from what was reported initially to the police about what the caregivers were doing prior to hearing the alarms.

At 11:23 AM Surveyor received Caregiver F's statement from Wellness Director I:
[Caregiver F]: Verbal Statement on 1/30/24

"During third shift, [Resident 1] was walking around memory care visibly upset stating that [his/her] stomach hurt. On second shift, earlier that night, [Resident 1] had thrown up and had diarrhea. We called triage on the second shift, and they said to encourage fluids because [Resident 1] had done this in the past. At around 0245, [Caregiver G] and I started doing rounds. At approximately 0330, [Caregiver G] and I were walking out [Resident 2's room.] When [sic] I walked toward the dining room, I heard a door alarm start to go off. I heard an overhead alarm that door one had been opened. When I went to check it out, I saw a police officer pushing on the door that led to AL. The officer exited MC and was walking toward AL. I followed [him/her] into AL. [S/he] asked me a couple of questions and let me know that [Resident 1] had left the building and was going to the ER. I returned to Betty's Harbor after the police officer was done talking to me."

Caregiver F's statement notes the caregivers were aware Resident 1 had a change in condition on 2nd shift including episodes of emesis and diarrhea that would nessecitate health monitoring. Caregiver F additionally acknowledges s/he was aware Resident 1 had been walking around memory care on the 3rd shift while being visibly upset and expressing abdominal pain. The POA was not contacted. Per record review no RN pain

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medication was given. Caregiver F stated both caregivers were "doing rounds" for 45 minutes during the time they were aware the resident was upset, in pain, and needed health monitoring for his/her change in condition. The statement does not address the discrepancy of how the caregivers did not hear the alarms sounding until 3:30 AM if they were on the floor doing rounds where the alarms were observed to be clearly heard.

Summary
On 01/12/2024 the provider did not have staff present to promptly meet the resident needs. Resident 1 was in pain and believed s/he was bleeding from his/her genitals, when s/he could not locate a caregiver and subsequently called 911 for help. The emergency services could not easily access the resident in the locked facility and could not locate staff on the premises. The resident was found alone, distressed and in pain. The caregivers did not immediately respond to the alarms and their time and place could not be accounted for over 30-40 minutes.

Cross Reference
N0158 DHS 83.12.(2)(a)Caregiver: Investigating Abuse & Neglect