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	0014097	A. BUILDING: _____ B. WING _____	C 10/03/2024

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HUNTINGTON PLACE MEMORY CARE 3	3902 EAST ROTAMER ROAD JANESVILLE, WI 53546

(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 09/24/2024-10/03/2024, Surveyors conducted a complaint investigation at Huntington Place Memory Care 3. Five deficiencies were identified. The complaint was substantiated. Census: 22	N 000		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report a serious injury resulting in emergency room treatment to the Department within 3 days for 2 of 2 resident records reviewed. Resident 1 sustained a fall on 09/16/2024 resulting in a laceration above left eye. Resident 2 sustained a fall on 06/20/2024 resulting in him/her receiving staples to their scalp. Findings include: On 09/24/2024, Surveyor reviewed resident records and identified the following:	N 165		

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

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N 165	Continued From page 1 Example 1: Resident 1 Resident 1 was admitted to the facility on 08/03/2018 with diagnosis including Parkinson's and frontotemporal dementia. Resident 1 had an activated healthcare power of attorney to assist in decision making. Resident 1's individual service plan (ISP) dated 05/27/2024 identified him/her as a fall risk. Resident 1's progress notes documented: "09/16/2024: Patient had a fall in the early morning. Vitals were taken and stable. Patient had a laceration open on top of the left eye. Patient was sent out to the hospital. Hospice, POA, and ADON called and informed of the fall." Resident 1's hospice notes documented: "09/16/2024: ....[Caregiver I] calls back to report EMS arrived and says that pt needs to go to the ER for stitches. [S/he] then handed the phone to EMT. EMT states, the lacerations is "pretty deep" and while the bleeding has stopped, [s/he] will need either glue or stitches.....Unwitnessed fall 9/16 when head/facial impact and traumatic injury-EMS arrived and emergent care provided at 1:45 a.m. Pt taken to SSM ED in Janesville for treatment of laceration above left eye. Per CAT nurse documentation-"laceration closed with glue, no dressing, keep dry and expect glue to fall off within a week." Pt returned to ALF where [s/he] resides after ED visit." On 09/24/2024, Surveyor reviewed Department records, which indicated no self-reports were submitted regarding Resident 1's laceration above left eye. Example 2: Resident 2	N 165		

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N 165	Continued From page 2 On 09/24/2024 at 11:05 AM, Surveyors observed Resident 2 sitting at a dining room table with Family Member C. Surveyors observed at least 2 staples on the top of Resident 2's head. Family Member C reported Resident 2 had a fall in June 2024 which resulted in him/her receiving staples. Family Member C reported the staples were supposed to be removed months ago. Family Member C reported s/he had brought this concern forward to Administrator A and Nurse B weeks ago and was told they would order a staple removal kit. Resident 2 was admitted to the facility on 04/16/2024 with a diagnosis of dementia. Resident 2 was their own legal decision maker. Resident 2's ISP dated 05/16/2024 identified him/her as a fall risk. Resident 2's progress notes documented: "06/20/2024: Resident has an unwitnessed fall @10:30 pm. Resident was calling for help and was found laying on [his/her] left side between the bed and the night side table. Wheelchair was found to the left of [him/her], call switch was still attached and clipped to shirt. Resident did fall and hit [his/her] head and was bleeding .... sent out 911. Contacted Nurse on call @ 10:36 pm, left message for POA @ 11:00pm. 09/02/2024: Writer gave resident a haircut per family request and res had two small stables (sic) in the top left side of head. [Nurse B] and [Family Member C] notified. Resident will have to see family doctor to have them removed." On 09/24/2024 at 11:10 AM, Surveyor interviewed Nurse B regarding Resident 2's staples still left in his/her head. Nurse B reported following a fall on 6/20/24, Resident 2 received staples. Nurse B stated Resident 2 had multiple hospitalizations	N 165		

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N 165	Continued From page 3 since June's fall and the staples were never removed. Nurse B confirmed a staple removal kit was ordered and the provider was waiting for the item to be delivered. Nurse B could not provide an answer to why the staples were not removed sooner. Nurse B stated s/he was responsible for submitting self-reports to the Department and if not sent, it's on him/her. On 09/24/2024, Surveyor reviewed Department records, which indicated no self-reports were submitted regarding Resident 2's staples. On 10/01/2024 at 2:34 PM, Surveyor interviewed Administrator A regarding the above concerns. Administrator A stated Nurse B was responsible for submitting self-reports to the Department and needed to do some investigating on why self-reports are not being submitted. Surveyor noted last month at the provider's other licensed memory care, the same concern was identified, and Surveyor provided the exact email address and fax number to the regional office, so self-reports could be submitted. Administrator A acknowledged an understanding of the concerns and stated s/he would talk with Nurse B.	N 165		
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.	N 348		

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This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure Resident 1 was free from mistreatment on 09/24/2024.

83.02(3) define "Activities of daily living" means bathing, eating, oral hygiene, dressing, toileting and incontinence care, mobility and transferring from one surface to another such as from bed to chair.

46.90(1)(f) define "Neglect" as the failure of a caregiver, as evidenced by an act, omission, or course of conduct, to endeavor to secure or maintain adequate care, services, or supervision of an individual, including food, clothing, shelter, or physical or mental health care, and creating significant risk or danger to the individuals physical or mental health.

Findings include:

On 09/06/2024, the Department received a complaint alleging concerns the provider was a no feed facility.

On 09/24/2024, Surveyor conducted a complaint investigation and identified the following:

The facility is licensed to serve up to 25 residents in the client groups of irreversible dementia/Alzheimer's disease and advanced age.

The provider's program statement documented: "Description of program goals- ...3) To provide the necessary physical assistance for persons with advanced age to complete activities of daily living ...5) To provide families of residents with the

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peace of mind that their family member is being assisted and cared for by staff that are specifically chosen to work with people experiencing irreversible dementia and the functional limitations accompanying persons with advanced age ...7) To provide a home with necessary physical and emotional supports for persons with irreversible dementia and persons with advanced age. Care and Services to be provided: 1. Assistance with activities of daily living ....9. Three meals a day and snacks."

Interviews:

On 09/19/2024 at 11:28 AM, Surveyor interviewed Legal Representative L who stated s/he was informed the facility is now a "no feed" facility by Resident 1's Managed Care Organization (MCO) team. Legal Representative L stated s/he was unaware that the facility did not offer feeding assistance and Resident 1 had lived at the facility since 2019. Legal Representative L reported s/he was very concerned Resident 1 would not get adequate nutrition if the facility did not offer feeding assistance because Resident 1 struggled to feed him/herself. Surveyor asked if the provider issued a 30-day notice regarding being unable to meet Resident 1's need for feeding assistance. Legal Representative L stated "no", and s/he was hopeful Resident 1 could remain at the facility since moves are hard on residents with dementia. Legal Representative L stated s/he was confused how a facility that specializes in memory care could not offer feeding assistance as residents with dementia often lose the ability to feed themselves as the disease progresses.

On 09/24/2024 at 8:00 AM, Surveyor interviewed Caregiver G regarding allegation the provider is a "no feed' facility. Caregiver G stated ever since

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s/he started 3 years ago; staff are directed not to offer residents feeding assistance. Caregiver G stated staff can encourage and help scoop up food, but do not offer feeding assistance throughout the whole meal.

On 09/24/2024 at 8:10 AM, Surveyors interviewed Nurse B regarding the "no feed facility" allegation. Nurse B stated over the last few weeks, the provider had discussions with Resident 1's MCO team regarding the facility as a "no feed" facility. Nurse B stated a staff member told Resident 1's MCO the facility is a "no feed" facility and that was not fully the case. Nurse B stated, "of course we would not let a resident starve, but we are not a skilled nursing facility and feeding residents is a skilled need." Nurse B stated assisted living staff are non-licensed and the provider did not have designated staff to sit with residents throughout their meal. Nurse B stated staff were expected to provide verbal cues or offer cutting up foods, steadying hands, but not offer full feeding assistance. Nurse B reported Resident 1's Parkinson's disease process led him/her having good/bad days with feeding him/herself but s/he had not had a change in eating habits. Nurse B reported Resident 1 can still feed him/herself and other times staff will offer the above assistance. Nurse B stated if Resident 1 could not feed him/herself then family would have to come in and offer assistance or hire an external caregiver.

On 09/24/2024 at 8:30 AM-8:45 AM, Surveyor observed breakfast in the dining room. Resident 1 was the only resident present. Resident 1 was observed in his/her Broda chair, stationed at a table, with his/her eyes closed, not eating. Resident 1 was served eggs, bacon, and sausage that was ground up. Resident 1 had weighted silverware and a glass with a top and

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handles as assistive devices to eat. Staff were observed walking past Resident 1 without attempting to wake Resident 1 up or offer feeding assistance until 8:45 AM.

On 09/24/2024 at 8:45 AM, Caregiver D came over to Resident 1 and started to prompt him/her to wake up, open his/her eyes, and take his/her spoon so s/he could cue him/her. Caregiver D stated Resident 1 usually missed breakfast and was tired if his/her eyes were still closed after getting up. Caregiver D stated if Resident 1's food items were not finger foods, the food ended up on the ground.

On 09/24/2024 at 8:50 AM, Surveyors interviewed Hospice Nurse H who stated s/he had been coming to the provider for over 2 ½ years and it was always their policy to not offer feeding assistance to residents. Hospice Nurse H s/he was not sure if it was due to staffing, but we tell families right away if the residents abilities change, family would be responsible or hired help would need to be arranged for feeding assistance. Hospice Nurse H stated Resident 1 recently had a cognitive and functional decline whereas before s/he could feed him/herself for every meal and had snacks in his/her room. Hospice Nurse H reported Resident 1 still had a good appetite but s/he is unable to feed him/herself for every meal. Hospice Nurse H reported Resident 1 had a couple choking incidents recently. Hospice Nurse H stated hospice sees Resident 1, 3x/week and had fed him/her myself, which took about 45 minutes. Hospice Nurse H noted hospice does not have any concerns with getting Resident 1 to eat when offered assistance with feeding.

On 09/24/2024 at 9:15 AM, Resident 1 was

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awake, sitting in his/her Broda chair, and placed at table in dining room. At 9:24 AM, Resident 1 attempted to use weighted utensils but dropped the fork and food went all over his/her lap. Surveyor observed a small amount of a muffin missing from Resident 1's plate. Caregiver D was passing by and reported s/he gave Resident 1 the muffin but attempts to eat the muffin were unsuccessful due to his/her contractures and tremors. Caregiver D reported Resident 1 spilt the muffin on his/her lap and floor. Caregiver D reported Resident 1 was having a bad morning related to being able to feed him/herself. Surveyors observed at least 75% of Resident 1's meal remained. At 9:42 AM, staff picked up utensil off the ground and provided Resident 1 with a new one. Staff put utensil in Resident 1's hand but did not offer any assistance to feed Resident 1. At 9:55 AM-10:00 AM, Caregiver G assisted Resident 1 with drinking, his/her eyes were open and answering yes/no questions. Caregiver G put the spoon in Resident 1's hand and s/he attempted a bite but was only successful with getting a small piece of sausage in his/her mouth and other food items in his/her lap. At 10:06 AM, Resident 1 took a bite of eggs. At 10:11 AM, Resident 1 attempted to take a bite of eggs, but started to shake and dropped his/her food and utensils. At 10:21 AM, staff asked Resident 1 if s/he was done with the meal and Resident 1 shook his/her head "yes."

From 9:15 AM -10:21 AM, Surveyor observed Resident 1 was successful in 2 of 4 bites attempted in feeding him/herself. Staff did not provide continuous supervision throughout the meal or offer feeding assistance during the 80 minutes observed.

On 09/24/2024 at 10:21 AM, Surveyor

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interviewed Caregiver D. Caregiver D shared the provider will write up staff if they assist residents with feeding.

On 09/24/2024 at 11:18 AM, Surveyor interviewed Nurse B and shared observations during Resident 1's breakfast. Surveyor noted Resident 1 was the last one in the dining room, so staff did not provide continuous supervision during the meal and assisted with other residents while periodically checking on Resident 1 if they walked by. Nurse B stated s/he worked in the building on 9/16/24 and observed Resident 1 feed him/herself and asked for seconds. Nurse B noted s/he helped with fluids, other than that Resident 1 ate very well. Nurse B stated after talking to their corporate nurse, the provider does not have a "no feeding" policy. Nurse B stated the provider does not monitor food/fluid consumption, but staff do report concerns to management. Nurse B denied staff get written up for feeding residents, but reiterated its not a task the provider offers assistance with for long term.

On 10/01/2024 at 12:17 PM, Surveyor interviewed Care Manager E regarding the above concerns. Care Manager E reported the MCO team was visiting for Resident 1's 6-month review at the beginning of September, when Resident 1 still had not eaten breakfast, Care Manager E consulted with a nurse from hospice who reported the provider is a "no feed" facility. Care Manager E stated s/he confirmed with staff about provider's policy and was told staff would get written up if they offer feeding assistance. Care Manager E stated s/he had been working in this industry for over 30 years and s/he had never heard of a CBRF not offering feeding assistance. Care Manager E stated s/he reached out to Nurse B regarding the provider being a "no feed"

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facility. Care Manager E reported Nurse B confirmed the provider was a "no feed" facility but could not produce a policy about this matter. Care Manager E stated s/he visited Resident 1 on 09/23/2024. Care Manager E reported Resident 1 indicated s/he was hungry, so upon lunch it took staff 15 minutes to find weighted utensils. Resident 1 did not have a straw in his/her drink, so MCO team had to find this. Care Manager E stated s/he was concerned Resident 1 was being neglected when staff did not offer feeding assistance. Care Manager E noted s/he was concerned of Resident 1's weight loss. Care Manager E reported Resident 1's legal representative did not know the facility did not offer feeding assistance.

Record review:

Resident 1 was admitted to the facility on 08/31/2018 with diagnosis including Parkinson's disease and frontotemporal dementia. Resident 1 had an activated healthcare power of attorney that assisted in decision making. Resident 1 was utilizing hospice services.

Resident 1's ISP, dated 05/27/2024 directed staff to "Dining/Eating: I need limited assist with meals (cutting up meats, steadying hands.) I can participate in part of the dining activity but may need adaptive equipment such as a large, handled spoon. I need verbal cures/reminder to attend meals; assist with menu selection; opening containers, packets, etc. I require continuous supervision while eating, require monitoring for swallowing problems. The ISP did not address if Resident 1 preferred to not have feeding assistance.

Resident 1's progress notes documented:

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N 348	Continued From page 11 09/16/2024: Writer observed resident at breakfast. [S/he] was able to feed [him/herself] although the sausage gravy texture was too difficult for [him/her] and [s/he] began to cough. [S/he] was able to clear after a few minutes and continued eating. Staff removed the sausage gravy and severed him another helping of oatmeal then when [s/he] was served two more helpings of soup, which [s/he] feed [him/herself.] 09/14/2024: Writer observed resident during mealtimes and resident had minimal difficulty feeding [him/herself]. Some assistance with [his/her] fork required but for the most part [s/he] fed [him/herself] and was able to hold [his/her] cup by the handle and take in fluids. At lunch [s/he] even asked for "more food" twice and had three helpings. "08/13/2024: Resident found on [his/her bathroom floor and complained of pain in [his/her] shoulder. Vitals taken and stable. Lift assist contacted to pick patient up they came lifted patient from floor to bed. 06/28/2024: At 1530, ...upon investigation and entering this resident's room writer visually observed resident prone on the floor with [his/her] head resting on [his/her] hands .....Upon assessment, no pain noted, ROM WNL. Writer encouraged resident to get on [his/her] hands and knees then put one foot under [him/her] to push him/herself up from the floor while holding on to [his/her] broda chair and writer for support. Once [s/he] got to [his/her] feet [s/he] pivoted and sat in [his/her] chair." Resident 1's hospice notes documented: "Nutritional concerns: difficulty swallowing. (Comment: decreased ability to use utensils). 3/24/23: Appetite remains good. Feeds self. 4/7/23: Staff reports an increase in difficulty in feeding self due to hand tremors resulting in need	N 348		

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N 348	Continued From page 12 to be fed by staff. Appetite remains the same. 5/5/23: Appetite still very good, but pt ability to feed self continuing to decline. 6/2/23: Ongoing difficulty self-feeding. Requires more assistance/feeding. 7/14/2023: Pt's [sister/brother] to provide utensils w/ straps so pt can feed self better. 8/1/2023: Pt having more success self-feeding with new strapped utensils. Pt occasionally does not use utensils appropriately and needs reminders from staff. Appetite good. 9/8/23: Pt struggles to eat with utensils but does well with finger foods. Snacks frequently. 9/29/23: Appetite varies from skipping meals to eating 100% of meal. Pt skipped breakfast this morning. 10/19/23: appetite varies. 11/7/23: Staff report pt usually eats 100% of meals. 12/6/23: Pt struggles with utensils but does well with assistance. Snacks frequently throughout the day. 08/03/24: Patient with increased weakness and fatigue resulting in need for increased assistance to complete all ADLs, including to be fed. Patient with increased instances of rigidity and freezing. Patient less mobile than previously, Increased confusion and forgetfulness. Increased episodes of bladder and bowel incontinence. Physical coordination decreasing and patient with increased difficulty propelling self in wheelchair. Continues to sleep majority of day. Reduced appetite. 08/08/24: .....Fluid encouraged. Pt reports increased difficulty swallowing. Pt did not want pureed diet. Risks reviewed. Chin tick technique demonstrated and pt encouraged to chew thoroughly. 8/15/24: Pt sleeping more, including during meals, Pt also has increased difficulty self-feeding, as well as chewing and swallowing. Pt eating 10-30% of 1-2 small meals.	N 348		

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8/27/24: [Resident 1] is a 66 year old [fe/male] with a hospice diagnosis of Parkinson's. [Resident 1] continues to live at the provider in Janesville, WI. Patient enrolled in hospice in November 2022. [Resident 1] requires increased assistance with ADLs, including feeding. [His/her] appetite is decreased.
8/28/24: ....Staff report [s/he] was up most of the noc and fell asleep around 5am. [S/he] will be woken close to lunch in order for [him/her] to eat. Appetite has been declining and [s/he] is needing more assist with feeding.
09/05/24: Writer made visit to provide weekly shower. On arrival pt. sleeping in bed, clothing and linens noted to be saturated in urine. Pt. assisted to shower chair with 2 assist, body is very stiff, noted an increase in arm and hand contractures ....My Choice RN and SW arrived, update give. Pt taken out to table for lunch, unable to feed [him/herself]. Writer fed pt [his/her] lunch, ate 100% of meal except bread stick. Pt coughs easily on fluids. Update to the Agrace team about pt. needing feeding assist as facility staff do not assist with feeding.
09/05/24: RN performed comprehensive assessment, medication reconciliation, and plan of care review ....Pt appears to have lost a significant amount of weight. Staff report pt sleeping through meals and having difficult feeding self and swallowing.
09/13/24: ....Collaborated with staff who declined needs or concerns. Upon arrival, patient sitting at the dining room table getting ready for lunch. Patient allowed for a visit before meal was served. Patient declined pain or discomfort. Patient reported that [s/he] had a good appetite."

Resident 1's admission agreement dated 03/01/2019 documented: "Basic services offered: Care-Included in the Bases Services Rate are the

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following: observation for changes in functioning; notification to family and other appropriate persons/agency of your needs; and bedside care for minor temporary illness. Services also may include assistance with bathing, grooming, dressing, prescribed medications, behavior management and other personal services."

Resident 1's weight chart noted the following: "01/08/2024- 212.5 lbs and 09/19/2024: 167 lbs."

Surveyor reviewed email communication between Care Manager E and Nurse B dated 09/06/2024:
"Case Manager RN J: [Nurse B],
I have not heard anything back from you or [Administrator A]. We need to follow up on what was reported to us yesterday from hospice.
Are you really a no feed facility and what exactly does that mean? Please get back to us ASAP.
The provider concern has been submitted.
Nurse B: [Case Manager RN J],
Yes, technically we are a no feed community but obviously we will not let one of our residents starve! We are not licensed as a skilled nursing facility and feeding assist is considered skilled care. You stated you don't feel [Resident 1] can feed himself. I know for a fact that [s/he] can as I worked on that unit during the supper meal this past Monday and I assisted [him/her] to hold a ham and cheese sandwich in [his/her] hand and [s/he] ate the entire thing on [his/her] own! Then, I assisted [him/her] to eat some peas and carrots and tater tots. [S/he] holds cups to drink fluids and [his/her] family provides Capri Sun pouch drinks and snacks for [him/her]. Feel free to reach out with any other questions or concerns!"

On 10/01/2024 at 2:34 PM, Surveyor interviewed Administrator A regarding the above concerns. Administrator A stated to his/her knowledge

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Resident 1 could still feed him/herself most days. Surveyor asked about other times when Resident 1 could not feed him/herself. Administrator A stated staff would encourage and give verbal cues, but not offer full feeding assistance. Administrator A stated if the need became chronic, family would have to help or hire an external caregiver. Administrator A noted if family could not meet provider's expectations, the provider would issue a 30-day notice. Administrator A stated Resident 1 was issued a 30-day notice in 2022, but due to his/her care needs MCO was unable to find alternative placement so 30-day notice was rescinded. Administrator A stated Resident 1 had not been issued a 30-day notice since. Administrator A stated Nurse B should have not told Resident 1's MCO team the provider was a "no feed" facility. Administrator A confirmed the provider does not offer feeding assistance since feeding was a skilled need and staff were non-licensed. Surveyor expressed concern whether staff neglected Resident 1 by not offering feeding assistance on 09/24/2024 during 80 minutes of breakfast observed. Surveyor reviewed neglect definition with Administrator A and noted food was being neglected when staff do not maintain adequate care and create a significant risk when not offering feeding assistance. Surveyor noted in observations and record review, Resident 1 often showed signs of needing assistance by of dropping his/her utensils, spilling food all over him/herself, and expressing a need of hunger/thirst. Administrator A acknowledged an understanding of the concern but denied staff neglected Resident 1. Surveyor asked if the provider specializes in memory care and residents with dementia often lose skills, how could this assistance not be offered by staff. Administrator A stated it had been like this since

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s/he started in 2022 and did not comment any further.

On 10/03/2024 at 8:05 AM, Care Manager E shared concerns s/he had while visiting Resident 1 on 10/02/2024: "I am reaching out to share with you my experience at the [Provider]. I arrived at 11:00am my member was still in bed in soiled depends with urine leaking through [his/her] pants. Member did get [his/her] am meds in applesauce, member reported that [s/he] was hungry, I had to go find a staff to ask them to get [him/her] up and change [him/her] . Member was extremely thirsty, I went and got [him/her] two glasses of water that [s/he] drank very fast. Members room was cleaned since I was there last week, members toilet was fixed. Member appeared not to have been shaved since last week either. I then left and went to the other building to check on another member ..... I then went back to my members building to see if they had gotten my member up and out of bed for lunch. Member was in [his/her] broda chair pushing [him/herself] back to [his/her] room. I went to member to ask [him/her] what [s/he] was doing, staff assisted me to get member back to [his/her] table, member was having a really bad day and could not bend or move [his/her] arm. Staff tried to coax member to hold [his/her] weighted spoon but member was unable to hold it [s/he] dropped the spoon. Staff then walked away, I assisted member with eating, while staff watched me. [Nurse K] came up to me to ask me what my plan was to get member fed. I told [him/her] that I expect that staff would assist the member, [s/he] then asked me if member should have a pureed diet, I explained that would be members PCP decision but that would be mute point [sic] if member cannot hold the spoon to get food to [his/her] mouth, member could not reach

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N 348	Continued From page 17 or hold [his/her] cup either. [Nurse K] walked away without helping my member or another resident that either could not or was not sure how to feed [him/herself], [s/he] left the table several times, staff brought [him/her] back but [s/he] would just stare [his/her] plate and watched me assist my member with eating finally [s/he] left and went to [his/her] room, staff stated that they would save [his/her] lunch for later when [s/he] was hungry. When I went to tell staff that my member was done eating as no one was still in the kitchen supervising the other residents that were still at the other tables and my member I witnessed another resident in the common room where the TV is, laying in [his/her] plate of food. I did tell staff as they were in the other kitchen no one was supervising the resident in the common area."	N 348		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the environment was safeguarded from conditions that are hazardous to residents. On 09/24/2024, Surveyors observed a considerable amount of mold-like substance in	N 358		

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N 358	Continued From page 18 the basement of the facility. Findings include: On 09/24/2024 at 11:51 AM, Surveyors interviewed Caregiver D and Caregiver F. Both staff reported concerns of seeing a lot of a mold-like substance on the walls in the basement. Staff led Surveyors to the basement and showed areas of concern. Staff did not know if residents were being affected by the mold-like substance. Staff reported management was aware of the concern but did not see any remediation being done. Upon walking into the basement, the doorframe had black mold-like substance towards the bottom of the frame, trim, and drywall. The unfinished area of the basement had large amounts of mold-like substance on the walls up near the ceiling. The mold-like substance went the length of walls, and many areas of concern were observed. On 10/01/2024 at 2:34 PM, Surveyor interviewed Administrator A regarding the above concerns. Administrator A stated the provider s/he was unaware of any mold-like substance in the basement. Surveyor expressed concern the amount of mold-like substance observed in the basement without a plan to remediate. Administrator A acknowledged an understanding of the concern but noted s/he would need to follow up with maintenance and provide additional documentation. On 10/01/2024 at 4:01 PM, Administrator A sent an email stating "On Mold like substance in basement issue: Maintenance is aware of the issue and is/has been working with a company for	N 358		

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cleanup and repair. It is from the heavy rain/flooding we had earlier this summer. "

On 10/02/2024 at 2:08 PM, Administrator A sent an email with a response from Maintenance Director M:
"Good afternoon,
I noticed multiple areas of suspicious growth in the basement on BTR 1 on September 11, 2024. I notified SE Cleaners and they came out the 13th to inspect. They said they would come up with a plan to treat the areas and get back to me. They came out again and looked at the areas some more a couple days later and said they would get me an estimate.
I went and looked around some more in the other side of the BTR 1-2 and also in BTR 3-4 and found some more areas in the basements and had them look at all areas. They said they would get back to me with a plan and quote for all areas.
I received the plan and quote on October 2nd. SE Cleaners stated they weren't a certified mold remediation specialist and if the areas needed to be tested, I would need a certified specialist.
State came in on September 24th and I was informed on the 1st of October they seen the areas in question. I then called First Onsite that night as I didn't feel comfortable with SE Cleaners not being certified and wanted professionals addressing the issue.
First Onsite came and inspected all the areas on October 2nd at 11:30am. They stated they would be able to get us a plan of action by the end of the day today."

SE cleaners estimate #688 documented:
"Growth removal in both BTR building
Timeline
9-11-24 received call from [Maintenance Director

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N 358	Continued From page 20 M] about staining on walls in basement 9-13-24 initial inspection of project Findings: 3909 (sic) building had growth noted on the basement landing on the west side stairway in the drywall as well as deformation/staining to the trim in the same area. the East side of the basement had a finished area that was visibly ok for most of the rooms and the hallway. The room is the most NW corner had considerable growth showing. This room had signs of growth on the walls greater than 4', a small area of the ceiling, the carpet, the trim and in the window well. Going into the unfinished area of the basement the mechanical room appeared to be fine. The electrical room had considerable growth on the walls and ceiling. The storage room on the left of it and the other small rooms on that same wall had significant growth showing. Several of the doors throughout the basement also had staining and bulging. We also found cracks in the cement walls in several areas." First Onsite estimate # 00594185 documented: "Mold remediation: Content manipulation, Building containment, Setting up and placing hepa rated air scrubbers, removal of the affected materials, cleaning and sanitizing, sealing the stud work once the materials are removed. Followed by post clearance testing. Comments Inspected building 3902, 3828, and 3840." Pictures were provided of mold growth areas. "How do molds affect people? Exposure to damp and moldy environments may cause a variety of health effects, or none at all. Some people are sensitive to molds. For these people, exposure to molds can lead to symptoms such as stuffy nose, wheezing, and red or itchy	N 358		

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N 358	Continued From page 21 eyes, or skin. Some people, such as those with allergies to molds or with asthma, may have more intense reactions. Severe reactions may occur among workers exposed to large amounts of molds in occupational settings, such as farmers working around moldy hay. Severe reactions may include fever and shortness of breath. How do you keep mold out of buildings and homes? Inspect buildings for evidence of water damage and visible mold as part of routine building maintenance. Correct conditions causing mold growth (e.g., water leaks, condensation, infiltration, or flooding) to prevent mold growth. Inside your home you can control mold growth by: Controlling humidity levels; Promptly fixing leaky roofs, windows, and pipes; Thoroughly cleaning and drying after flooding; Ventilating shower, laundry, and cooking areas." (Source: Centers for Disease Control and Prevention Website, Basic Facts about Mold and Dampness, November 14 2022, https://www.cdc.gov/mold/faqs.htm (retrieval date- October 2nd, 2024).) Summary: The provider did not ensure the environment was safe when mold-like substance was observed on 09/11/2024, inspected 09/13/2024, and no further follow up until 10/01/2024 (18 days) when Maintenance Director M was notified the Department was aware of the mold-like substance.	N 358		
N 388	83.35(3)(c) Implement, follow the individual service plan	N 388		

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Implementation. The CBRF shall implement and follow the individual service plan as written.

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure the individual service plan (ISP) for 1 of 2 residents was implemented and followed as written.

Resident 1's ISP directed staff to provide 2 or more staff while toileting. On 09/24/2024 at 10:25 AM, Resident 1 was observed being toileted with 1 staff member.

Findings include:

On 09/24/2024, Surveyor conducted a complaint investigation and identified the following:

Resident 1 was admitted to the facility on 08/31/2018 with diagnosis including Parkinson's disease and frontotemporal dementia. Resident 1 had an activated healthcare power of attorney that assisted in decision making. Resident 1 was on hospice services. Resident 1's ISP, dated 05/27/2024 directed staff "Toileting, I require the assist of 2 or more staff with toileting. I need continuous supervision during toileting activities and/or periodic assistance emptying my urinal at night. I need physical assistance with my toileting tasks r/t fall risk. Transfers: My transfer assistance need is Physical assistance or Dependent and I require the assistance of 2 staff members for transfers."

On 09/24/2024 at 10:25 AM, Surveyors observed Caregiver D push Resident 1 in his/her Broda chair from the dining room to his/her bedroom. Caregiver D reported s/he was toileting Resident 1. Caregiver D reported Resident 1's toilet tank lid

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N 388	Continued From page 23 had been missing since s/he started in March 2024. While talking with Surveyors, Caregiver D started to assist Resident 1 with toileting by him/herself. At 10:30 AM, Surveyor observed Caregiver D exit Resident 1's room without any other staff assisting with toileting. On 09/24/2024 at 11:53 AM, Surveyor interviewed Caregiver D and Caregiver F. Both staff reported concerns the provider was not staffing at least 2 staff per shift. Both staff observed the resident roster and identified Resident 1 as a 2 person assist for activities of daily living including toileting. On 10/01/2024 at 2:34 PM, Surveyor interviewed Administrator A regarding the above concerns. Administrator A confirmed Resident 1 was a 2-person assist for toileting. Administrator A acknowledged an understanding of the concern and stated retraining would need to occur.	N 388		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the living environment was clean and homelike. Findings include:	N 481		

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N 481	Continued From page 24 On 09/24/2024 at 9:33 AM, Surveyor toured Resident 1's room and observed the following: -Wall next to the recliner had many areas with dust and dirt build up. -Recliner chair had many dried stains and food crumbs. -Walls throughout the room had many areas with dust and dirt build up and discolored paint. -Bathroom walls had large areas of discolored paint and chipped drywall. -Toilet was missing a tank lid. -Wall next to the toilet had black streaks marks. -Toilet paper rod was missing. -Toilet seat riser contained dried brown matter consistent with fecal matter. -Toilet bowl had a yellow/brown appearance, due to what appeared to be an irregular cleaning routine. -Bathroom sink contained a used glove and wash cloth. -Garbage can next to the toilet did not contain a liner. -Large garbage can to the left upon entering the room was full of trash without a liner. On 09/24/2024 at 10:22 AM, Surveyor interviewed Caregiver D regarding the condition of Resident 1's room. Caregiver D stated s/he started 7 months ago and his/her room has always looked like this, including a missing tank lid to the toilet. Caregiver D stated maintenance requests are filled out but nothing is done about it. On 10/01/2024 at 12:17 PM, Surveyor interviewed Care Manager E regarding the condition of Resident 1's room. Care Manager E reported concerns with the environment of	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014097	A. BUILDING: _____ B. WING _____	C 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 481	Continued From page 25 Resident 1's bedroom and bathroom. Care Manager E stated Resident 1's toilet was missing a tank lid for months. Care Manager E stated s/he brought these concerns forward to Administrator A and Nurse B, but no response is provided. On 10/01/2024 at 2:34 PM, Surveyor interviewed Administrator A regarding the above concerns. Administrator A stated Resident 1 is a larger man/women and s/he often causes damage to the environment in his/her room. Administrator A stated repairs have been made to Resident 1's room over the years, but due to his/her diagnosis and behaviors, damages to the room continue. Administrator A acknowledged Resident 1's room was not homelike but noted s/he only found out about the missing toilet tank lid a few weeks ago. Administrator A stated s/he would need to talk maintenance about making the necessary repairs.	N 481		