STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015325	A. BUILDING: _____ B. WING _____	C 02/12/2025

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CHARTER SENIOR LIVING OF HASMER LAKE	N168 W22022 MAIN ST JACKSON, WI 53037

(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 An investigation into 5 complaints and a self-report was conducted at Charter Senior Living of Hasmer Lake CBRF on 02/04/2025 with information gathered through 02/12/2025. As a result of this survey four deficiencies were identified. Four of 5 complaints were substantiated. Census: 14	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 staff and family interviews and record review, the provider did not ansure the safety of	N 158		

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

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all residents and did not maintain documentation of an investigation to rule out abuse or neglect for 1 of 2 allegations of abuse to Residents 1, 2, 3, and 4. Initial concerns of abuse in October 2024 had no documentation of the investigation. The provider allowed CG (Caregiver) - D to continue working in the provider's RCAC and returned to work in the CBRF on 12/14/24. On 01/21/2025 new allegations of abuse by CG - D were made known to the facility, investigated, and resulted in termination of CG - D.

Findings include:

On 02/04/2025 Surveyors reviewed concerns brought to the State Agency of possible abuse and neglect to Residents 1, 2, 3 and 4. All residents reside on the Memory Care Unit.

Surveyor spoke with FMBR (Family Member) - E on 02/04/25 at 11:15 AM who was sitting with Resident 1 at the dining table. FMBR - E told Surveyor s/he spoke with OS (Operations Specialist and Previous Executive Director) - B in the end of October 2024 about concerns of possible mistreatment to Resident 1 and other residents by CG (Caregiver) - D. FMBR - E stated CG - D was removed from working on the Memory Care Unit but was back a month or so later.

In an interview with Surveyor on 02/04/25 at 12:10 PM, ED (Executive Director) - A said s/he started employment in November 2024 and said s/he had no copy of an investigation or knowledge of the previous allegations of abuse by CG - D in October 2024. ED - A said that would have been done by OS - B and HWD (Health and Wellness Director) - F who resigned in December 2024. ED - A confirmed CG - D worked in the

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N 158	Continued From page 2 RCAC and CBRF until 01/21/25 when suspended due to allegations of potential abuse. ED - A said a separate incident of witnessed misconduct by CG - D to Resident 5 were made known to him/her on 01/21/25 and investigated on 01/21/25 to 01/23/25 resulting in termination of CG - D on 01/23/25. ED - A stated CG - D was removed from the schedule on 01/21/25 pending investigation. ED - A provided documentation of this abuse investigation and the Caregiver Misconduct Report sent to the Office of Caregiver Quality. During an interview with Surveyor on 02/04/25 at 2:45 PM, OS - B verified receiving a report that CG - D of mistreatment of residents in October 2024. OS - B said an investigation was completed and a decision was made to transfer CG - D to the RCAC for further training as it did not seem a good fit for him/her to be working in Memory Care. OS - B said the investigation showed no abuse but rather poor technique in dealing with residents. OS - B confirmed there was no copy kept of the investigation done. OS - B indicated HWD - C would have completed that investigation report but it could not be found and HWD - C no longer worked at this facility. OS - B confirmed there was no report sent to the Office of Caregiver Quality as the decision was that it was not abuse. OS - B said s/he was not involved with CG -D coming back to work in the Memory Care Unit. Facility staffing schedules showed CG - D worked in the Memory Care Unit of the CBRF on 12/14/24, 12/23/24, 12/25/24, 12/26/24, 12/28/24, 12/29/24 and 12/31/24 on the 2:30 PM to 11:00 PM shift and continued working until 01/21/2025.	N 158		

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N 158	Continued From page 3 The provider had no record of the investigation of alleged abuse in October 2024 by CG - D and allowed CG - D to continue working in this facility in the RCAC and returning to work in the Memory Care Unit of CBRF on 12/14/24. On 01/23/25 CG - D was terminated following another investigation into other complaints of alleged abuse in the CBRF.	N 158		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not ensure immediate notification to a resident's legal representative when there was an incident or injury to the resident. On 11/20/2024 at 3:30 AM, Resident 4 had an unwitnessed fall in [her/his] bedroom and was assisted back to bed by staff. Hours later Resident 4 began complaining of left hip pain and was transported to the hospital and diagnosed with a left hip fracture. There was no evidence Resident 4's legal representative was immediately notified of the fall. Additionally, Resident 4's legal representative was not made	N 169		

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aware of the fall or the need for hospital transfer, until approximately 8 and a half hours later, when Resident 4's legal representative arrived at the facility to take Resident 4 to a scheduled appointment and found Resident 4 not to be at the facility.

Resident 6 had unwitnessed falls on 10/06/2024, 10/08/2024, 10/31/2024, 11/15/2024, 12/03/2024 and 12/09/2024. There was no evidence Resident 6's legal representative was immediately notified of the fall incidents

This is a repeat deficiency. See Statement of Deficiency (SOD) RT4K12 dated 06/11/2024.

Findings include:

On 12/06/2024, the department received a complaint alleging lack of communication regarding resident falls.

The facility's Policy and Procedure titled, "Incident/Unusual Occurrence" revised 4/2022 indicated, "The purpose of this policy and procedure is to provide an overview of the process for completing an Incident Report; describe types of occurrences that would warrant an Incident Report being completed and what to do when responding to a fall. Procedure: 1. An incident report form should be filled out completely for any incident/unusual occurrence ...3. Notify the resident's responsible party of the incident/unusual occurrence. Document their response, date, and time of notification in the medical record..."

RESIDENT 4:

On 02/04/2025, Surveyor reviewed the medical

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record for Resident 4. Resident 4 was admitted to the facility on 10/01/2024 with diagnoses to include diabetes, dementia, and myelodysplastic syndromes cancer. Additionally, the medical record indicated Resident 4 had a legal representative, was ambulatory and required staff assistance with ADL's (Activities of Daily Living) and transfers.

A fall incident report for Resident 4 dated 11/20/2024 indicated, "At 3:30 AM, [Resident 4] was yelling for help. Upon caregiver entering [Resident 4's] bedroom [s/he] observed [Resident 4] on the floor. [Resident 4] stated, "My feet got caught in the wheels of my wheelchair. [Resident 4] was wearing [her/his] pendent: however, [s/he] did not use it. [Resident 4] was able to move all limbs and denied any pain at this time. At 6:29 AM, when caregiver was doing rounds and checked on [Resident 4], [s/he] was complaining of left hip pain. EMS was notified and resident was transported to the hospital." The fall "Incident Tasks" indicated, "11/21/2024, [Resident 4] remains in the hospital. Writer spoke with hospital social worker today who stated [Resident 4] fractured [her/his] left hip." Additionally, the fall "Incident tasks" indicated Resident 4's legal representative was notified of the fall on 01/09/2025, fifty days later.

***No documentation was located within Resident 4's medical record or observation notes indicating Resident 4's legal representative was notified immediately of the fall incident or hospital transfer on 11/20/2024.

On 02/06/2025 at 8:45 AM, Surveyor interviewed Legal Representative I and Family Member G regarding Resident 4. Legal Representative I and Family Member G stated, "On 11/20/2024,

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N 169	Continued From page 6 [Resident 4] had an unwitnessed fall in [her/his] bedroom. Staff got [Resident 4] up off the floor into [her/his] wheelchair and then into bed. Around 6:30 AM, staff sent [Resident 4] out to the hospital. The facility never called to tell us [Resident 4] fell or that [s/he] was sent out to the hospital. We found out about [Resident 4's] fall and hospital transfer when we arrived at the facility around noon on 11/20/2024 to take [Resident 4] to a schedule appointment. [Resident 4's] fall resulted in a fractured left hip ...On 11/21/2024 at 3:30 PM, we requested a meeting with [Executive Director A], [Operations Specialist B] and [Health and Wellness Director C]. During the meeting we told them our concerns about [Resident 4's] fall and not being notified until we showed up at the facility to take [her/him] to a scheduled appointment." On 02/04/2025 at 1:30 PM, Surveyor interviewed Operation Specialist B and Regional Clinical Nurse Specialist I regarding the above information and notification to Resident 4's legal representative. Operation Specialist B and Regional Clinical Nurse Specialist I stated, "We would expect staff to notify the legal representative immediately after a fall, even if it's in the middle of the night." Operation Specialist B and Regional Clinical Nurse Specialist I verified Resident 4's Legal Representative was not immediately notified of Resident 4's fall on 11/20/2024. RESIDENT 6: On 02/04/2025, Surveyor reviewed the medical record for Resident 6. Resident 6 was admitted to the facility on 10/01/2024 with diagnoses to include Parkinson's. Additionally, the medical record indicated Resident 6 had a legal	N 169		

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representative and was receiving hospice services. Resident 6's ISP dated 01/13/2025 indicated the resident was non-ambulatory and required staff assistance with all ADL's including transfers.

On 02/04/2025, Surveyor reviewed Resident 6's Incident Reports from 10/01/2024 through 02/04/2025 which revealed the following:

*10/06/2024- "Upon entering resident room resident was on the floor. No pain, no bruising, nurse notified." The fall "Incident Tasks" indicated Resident 6's legal representative was notified of the fall on 10/19/24, thirteen days later.

*10/08/2024- "Caregiver found [Resident 6] on the floor [s/he] was in no pain. Vitals taken and nurse notified." The report did not indicate Resident 6's legal representative was notified.

*10/31/2024- "While completing rounds writer found resident on the floor in [his/her] room. [Resident 6] was sitting on the floor next to [his/her] bed. [Resident 6] denied pain and refused medical services. [Resident 6] stated [s/he] was trying to get out of bed to find a soda." The fall "Incident Tasks" indicated Resident 6's legal representative was notified of the fall on 11/10/2024, ten days later.

*11/15/2024- "Writer was notified that caregiver was doing rounds and upon entering [Resident 6's] room, [s/he] was on [his/her] bedroom floor. No complaints of pain or discomfort..." The report did not indicate Resident 6's legal representative was notified.

*12/03/2024- "Resident was found on the floor by [his/her] bed. From what staff saw it seems as if

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N 169	Continued From page 8 [s/he] slid out of bed onto [his/her] butt. Earlier [s/he] told staff [she's] trying to go to [his/her] spouse and that no one could deny [him/her] of that. Hospice was contacted and Nurse was notified." The report did not indicate Resident 6's legal representative was notified. *12/09/2024- "Resident was on the floor in no pain ...Hospice was notified they said to administer PRN. Resident was put back in bed..." The report did not indicate Resident 6's legal representative was notified. ***No documentation was located within Resident 6's medical record or observation notes indicating Resident 6's legal representative was notified immediately of the fall incidents on 10/06/2024, 10/08/2024, 10/31/2024, 11/15/2024, 12/03/2024 and 12/09/2024. On 02/06/2025 at 8:45 AM, Surveyor interviewed Legal Representative I and Family Member G regarding Resident 6. Legal Representative I and Family Member G stated, "There has been a continuous lack of communication regarding [Resident 6's] falls. [Resident 6] has had several falls and we're not notified of all the falls, but instead were told days later by facility staff or hospice staff. There's been times we were notified of [Resident 6's] falls and other times we were not. On two occasions the facility sent [Resident 6] to the hospital while on hospice care, without notifying hospice. Overall communication with the facility has been our biggest concern." On 02/05/2025 at 12:15 PM, Surveyor sent an email to Executive Director A and Operation Specialist B requesting evidence Resident 6's legal representative was notified immediately of the 10/06/2024, 10/08/2024, 10/31/2024,	N 169		

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N 169	Continued From page 9 11/15/2024, 12/03/2024 and 12/09/2024 falls. On 02/06/2025 at 11:24 AM, Operation Specialist B sent Surveyor an email indicating [s/he] was unable to locate any additional documentation.	N 169		
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, interviews and record review, the provider did not provide supervision appropriate to the resident's needs for 1 of 1 resident reviewed. Resident 6 had falls, was at risk for falls and required routine safety checks. Upon admission, Resident 6 had video monitoring equipment installed, within his/her personal room by Resident 6's legal representative. On 12/04/2024 at approximately 11:30 PM, Resident 6 was observed by the room camera attempting to get out of bed and sliding to the floor. Staff did not complete the routine safety checks while Resident 6 was in her/his bedroom during the night hours. As a result, Resident 6 laid on his/her bedroom floor all night without any	N 426		

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assistance from staff from 11:30 PM until 6:45 AM (over seven hours). At 6:45 AM, Resident 6's family called 911 as family was unable to reach staff. First responders arrived shortly before 7 AM and assisted Resident 6 back to bed, without injury.

The facility received a license on 12/01/2014 as a Class CNA (non-ambulatory) facility which serves residents who are ambulatory, non-ambulatory, or semi-ambulatory, but one or more of whom are not physically or mentally capable of responding to a fire alarm by exiting the CBRF without help or verbal or physical prompting. The facility is licensed to care for 24 residents with programming for residents including irreversible dementia, Alzheimer's disease, and advanced age.

Findings include:

On 12/06/2024, the department received a facility self-report which indicated, "[Resident 6] attempted to get out of bed at approximately 11:30 PM on 12/04/2024. [Resident 6] was observed via room camera sliding to the floor from [his/her] bed. [Resident 6] remained on the floor and attempted to crawl to [his/her] mechanical lift until 6:45 AM. [Former Caregiver F] did not perform required four times per shift checks on the resident, resulting in [Resident 6] remaining on the floor from 11:30 PM until 6:45 AM. At 6:45 AM, [Resident 6's] family attempted to reach staff; family called 911. First responders arrived and entered the building shortly after 7:00 AM. [Resident 6] was assisted back to [his/her] bed without injuries..." Additionally, the self-report indicated the following actions were taken to ensure Resident's health safety and well-being, "[Former Caregiver F] was immediately

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suspended pending investigation, all staff are required to attend mandatory misconduct training on 12/17/2024, caregiver will be reported to caregiver misconduct, and resident will continue to be monitored."

On 02/04/2025, Surveyor reviewed the medical record for Resident 6. Resident 6 was admitted to the facility on 10/01/2024 with diagnoses to include Parkinson's. Additionally, the medical record indicated Resident 6 had a legal representative and was receiving hospice services. Upon admission, Resident 6 had video monitoring equipment installed, within his/her personal room by Resident 6's legal representative. Surveyor observed a handwritten sign on Resident 6's door stating, "Camera in Use."

On 02/04/2025, Surveyor reviewed Resident 6's ISP (Individual Service Plan) dated 01/13/2025 which indicated, the resident was non-ambulatory, utilized a mechanical lift for transfers, and required staff assistance with all ADL's (Activities of Daily Living) including transfers. Additionally, the ISP noted Resident 6 was a high fall risk and had a total of twelve falls. An intervention listed on the ISP dated 10/07/2024 indicated, "Ensure to do safety checks regularly..." The ISP also indicated, "Safety checks four or more each shift...Caregivers are required to complete routine safety checks on [Resident 6] four times throughout the shift."

A Fall Incident Report dated 12/05/2024 at 7:00 AM indicated, "[Resident 6] was found next to [his/her] bed on the floor. 911 called for evaluation and treat if indicated. Hospice, MD, nurse, ED and family aware."

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N 426	Continued From page 12 On 02/04/2025, Surveyor reviewed the facility's investigation regarding the incident with Resident 6. The investigation indicated, "[Resident 6], attempted to get out of bed at approximately 11:30 PM on 12/04/2024. [Resident 6] was observed via room camera sliding to the floor from [his/her] bed. [Resident 6] remained on the floor and attempted to crawl to [his/her] sit to stand until 6:45 AM on 12/05/2024. Third shift caregiver, [Former Caregiver F], did not perform frequent checks on resident. This resulted in [Resident 6] remaining on the floor from 11:30 PM until 6:45 AM. At 6:45 AM, [Resident 6's] family attempted to reach staff and called 911. First Responders arrived and entered the building shortly before 7 AM. [Resident 6] was assisted back to [his/her] bed, without injuries...[Former Caregiver F], was suspended pending the investigation. [Resident 6], was evaluated by first responders and [Regional Clinical Nurse Specialist H]. [Former Caregiver F's] employment was terminated on 12/11/2024 for unsatisfactory work performance, safety violation, and policy and/or procedure violation." The investigation included an interview from the accused employee [Former Caregiver F] who worked during the night hours on 12/04/2024. Former Caregiver F indicated Resident 6 was checked on at 2 AM and 4 AM, but Former Caregiver F did not enter the room completely. The facility's conclusion to the investigation revealed Resident 6 was not checked on throughout the night of 12/04/2024 into the morning of 12/05/2024. Additionally, Former Caregiver F's "Termination Statement" indicated, "On 12/04/2024, an accusation of negligence in not caring for a resident during an 8-hour shift was reported. Upon investigation, the accusation of negligence of not caring for a resident during	N 426		

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your entire shift is proven to be factual via video evidence."

On 02/11/2025, Surveyor reviewed the JFD (Jackson Fire Department) "Prehospital Care Report" which indicated, "JFD was dispatched to the report of [Resident 6] on the floor of [his/her] room in the care facility. This was reported by a third-party who was able to see on a remote camera, and the report stated [Resident 6] was on the floor since midnight...EMS (Emergency Medical Services) arrived on scene and experienced a delay in entering the facility due to the front door being locked...The staff was surprised to see EMS and inquired who we were there to see. EMS made contact in [Resident 6's] room. [Resident 6] was on the floor between [his/her] wheelchair and a Hoyer lift. [Resident 6] was alert and able to answer questions. [Resident 6] stated no pain or injuries, and none were observed by EMS. [Resident 6] was assisted to a sitting position then lifted to a standing position before being placed in the wheelchair. [Resident 6] was asked if [s/he] wanted to be evaluated and [Resident 6] refused...The oncoming staff came into the room and was briefed by EMS on the incident...12/05/2024 the JFD service reported on incident...The incident occurrence was at Charter Senior Living of Hasmer Lake CBRF. The unit was notified at 06:47, responded at 06:52, arrived at the scene at 06:56 and completed the call at 07:12..."

On 02/06/2025 at approximately 8:45 AM, Surveyor spoke with Resident 6's Family Member G regarding the above incident with Resident 6. Family Member G indicated video monitoring equipment was installed in Resident 6's bedroom upon moving in and stated, "On 12/04/2024, at

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N 426	Continued From page 14 approximately midnight, the camera footage revealed [Resident 6] fell out of bed and laid on the floor until 6:50 AM. No one checked on [him/her]. [Resident 6] crawled to [his/her] sit to stand lift and was using the controls to try to get it to work. I attempted to call the building, but the phone was not working. I then called 911 to help [Resident 1] off the floor." On 02/04/2024 at 2:50 PM, Surveyor interviewed Executive Director A regarding the incident with Resident 6. Executive Director A verified Resident 6 required supervision and safety checks. Executive Director A stated, "Based on my investigation [Former Caregiver F] did not complete the 2-hour safety checks for [Resident 6] throughout the night shift on 12/04/2024." On 02/04/2025 at 1:30 PM, Surveyor spoke with Operation Specialist B regarding the incident with Resident 6. Operation Specialist B verified [Former Caregiver F] failed to complete the 2-hour safety checks on Resident 6 throughout the night on 12/04/2024. Operation Specialist B stated, "When a resident is on safety checks, the expectation is for staff to lay eyes on the resident, make sure their environment is safe, the resident is clean, their body is positioned in bed and to check if the resident needs anything...[Former Caregiver F] stated [s/he] checked on [Resident 6] by opening [Resident 6's] bedroom door, but [Former Caregiver F] did not enter the room to physically look or see [Resident 6] or fully check on [Resident 6]." Operation Specialist B indicated the facility completed an investigation, suspended and terminated [Former Caregiver F]...Based on the investigation we reported the incident to OCQ (Office of Caregiver Quality) and re-educated all staff on 12/17/2024 regarding misconduct/neglect.	N 426		

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N 426	Continued From page 15 In conclusion, the facility did not provide adequate supervision to meet Resident 6's needs. Staff failed to complete safety checks while the resident was in her/his bedroom during the night hours on 12/04/2024 into 12/05/2024; as a result, Resident 6 laid on his/her bedroom floor for over seven hours without assistance from staff.	N 426		
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, interviews and record review the provider did not ensure a living environment that was safe, clean, comfortable and homelike for Residents. The CBRF has 2 floors with resident bedrooms and one elevator located in the lobby on the first floor. On 12/01/2024, Resident 6 had to be stair lifted back to his/her second-floor bedroom by the local fire department because staff did not know how to properly operate the elevator. Staff were not trained prior to or following this incident on the safety guidelines and proper usage of the elevator. At the time of survey there were eight residents who resided on the second floor, six of the eight residents either used a wheelchair for mobility or needed assistance with mobility.	N 481		

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N 481	Continued From page 16 The facility received a license on 12/01/2014 as a Class CNA (non-ambulatory) facility which serves residents who are ambulatory, non-ambulatory, or semi-ambulatory, but one or more of whom are not physically or mentally capable of responding to a fire alarm by exiting the CBRF without help or verbal or physical prompting. The facility is licensed to care for 24 residents with programming for residents including irreversible dementia, Alzheimer's disease, and advanced age Findings include: On 12/06/2024 and 12/10/2024, the department received concerns regarding the facility's elevator not working. On 02/04/2025 at 9:30 AM, Surveyor toured the facility with ESD (Environmental Services Director)-J. The building consisted of a basement, first floor and second floor. The basement contained the kitchen, storage and garage area. The first floor of the building contained the lobby, a hearth room, staff offices, and seven CBRF bedrooms. The second floor contained a community area and ten CBRF bedrooms. The building has one elevator, located in the lobby on the first floor. The elevator travels to the basement, first floor and second floor. Surveyor observed the elevator. The elevator had a sign on the door that indicated, "ATTENTION ELEVATOR FOR RESIDENTS AND STAFF USE ONLY PLEASE ASK STAFF FOR ASSISTANCE." ESD-J indicated the elevator was a hydraulic elevator and was unique and different than normal elevators due to the size and operation. ESD-J demonstrated for Surveyor how the elevator operated. Surveyor noted the elevator consisted	N 481		

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of an outer wooden door that opened out and to the right. Once the wooden door opened out, an accordion style gate was observed which slid to the right. ESD-J indicated, the outer wooden door needs to be close first and will do so automatically, then the bifold gate must be manual closed by sliding the gate across the track making contacted with a magnetic strip on the opposite side of the door. Once the wooden door and bifold gate is closed properly staff can then press the button for the desired floor. ESD-J stated, "Staff need to follow these steps on closing the doors prior to pressing any buttons or the elevator may not run...I do know kitchen staff will leave the elevator door propped open in the basement so meals can by brought up to the first and second floor. If the kitchen staff leaves the elevator door open in the basement the elevator will not run. Staff need to go down to the basement to see if the door was left open if the elevator isn't running." ESD-J indicated, "The elevator is functioning properly and has been inspected by a professional on 1/24/2025, with no concerns. If the elevator does not run properly, it's because of "User error." ESD-J went on to say. "If staff and visitors know how to work the elevator it will work." Surveyor then asked ESD-J if the facility had an elevator policy and procedure outlining safety guidelines, proper usage of the elevator, including how to enter and exit, and what to do in case of an emergency. ESD-J verified the facility did not have an elevator policy and procedure and stated, "I train new staff and show them how to use the elevator, but don't document the training."

On 02/04/2025, during the survey visit, Surveyors observed a total of 8 residents living on the second floor. The only way residents could access the first floor was to walk up and down

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multiple stairs or use the elevator. Six of the 8 residents who resided on the second floor either used a wheelchair for mobility or needed assistance with mobility.

On 02/11/2025, Surveyor reviewed the JFD (Jackson Fire Department) "Prehospital Care Report" which indicated, "12/01/2024 the JFD service reported on incident...The incident occurrence was at Charter Senior Living at Hasmer Lake. The unit was notified at 19:39, responded at 19:45, arrived at the scene at 19:48, arrived at the destination at 20:01 and completed the call at 20:05. JFD was dispatched for report of the main elevator not working and a resident needed to be moved from the first floor to the second floor of the facility. Requested for a non-emergent assist in moving [Resident 6]. Upon arrival at scene, [Resident 6] is found sitting with family in [his/her] wheelchair in main reception area. Family states the elevator is broken, and facility is attempting to make arrangements for its repair. [Resident 6] needed to be brought upstairs. [Resident 6] was lifted with a high low lift and placed on our stair chair and secured. Two JFD members were able to use stair chair to bring [Resident 6] upstairs to room. [Resident 6] was then lifted high low and placed in bed with family at side. No assessment was required, and no care services were needed besides the lift and move..."

On 02/04/2025, Surveyor reviewed the medical record for Resident 6. Resident 6 was admitted to the facility on 10/01/2024, resided on the second floor with diagnoses to include Parkinson's. Resident 6's ISP (Individual Service Plan) dated 01/13/2025 indicated, the resident was non-ambulatory, utilized a mechanical lift for transfers, and required staff assistance with all

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N 481	Continued From page 19 ADL's (Activities of Daily Living) including transfers. On 02/06/2025 at approximately 8:45 AM, Surveyor spoke with Resident 6's Family Member G regarding the above incident with Resident 6. Family Member G stated, "On 12/01/2024, our family held a dinner party in the first-floor hearth room. At 3:30 PM we brought both [Resident 6] and [Resident 4] down the elevator. At approximately 6 PM we went to take them back upstairs. We were able to successfully get [Resident 4] upstairs. When the elevator came back down, I took [Resident 6] on to it. We followed the instructions, but the elevator would not work causing us to get stuck inside. We asked staff to assist in manually opening the doors so we could get off the elevator. We then proceeded to triage the situation and tried to see if or where it was getting stuck and how to get it to operate. We were disappointed to find out quickly that none of the staff seemed educated or knew what to do in this kind of emergency. Attempts were made to call leadership to assist, with no success. [Health and Wellness Director C] directed staff to call the JFD. The JFD came and stair lifted [Resident 6] back to [his/her] room. This took until approximately 8 PM to be resolved. It was clear staff did not know how to handle this situation. We've been stuck in the elevator before, and staff don't know what to do...Some staff didn't even know the facility had an elevator ..." On 02/06/2025 at 10:20 AM, Surveyor interviewed Team Lead/Caregiver-K. Team Lead/Caregiver-K verified s/he was working on 12/01/2024 during the above incident with Resident 6. Team Lead/Caregiver-K stated, "I was there...We couldn't get the elevator to work	N 481		

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so we had to call the JFD to bring [Resident 6] back upstairs...We tried to call [ESD-J] to help, but [s/he] didn't answer [his/her] phone. We did get a hold of [Health and Wellness Director C] who told us to call the JFD for assistance." Surveyor then asked Team Lead/Caregiver-K if s/he received any training on the proper usage of the elevator and what to do in case of an emergency. Team Lead/Caregiver-K confirmed s/he did not receive any training on the use of the elevator and verified the facility had no elevator policy or procedure. Team Lead/Caregiver-K stated, "[ESD-J] said [s/he] was going to come and show me how to use the elevator today."

On 02/04/2025 at 10 AM, Surveyor interviewed Executive Director A regarding the above incident with Resident 6. Executive Director A stated, "I know there's been a lot of concerns with the elevator and it's been a topic of conversation." Surveyor then ask if staff received any training on the procedure for the elevator. Executive Director A indicated s/he was unsure if any training was completed for staff and stated, "If there was training [ESD-J] would have the training."

On 02/05/2025 at 10:15 AM, Surveyor spoke with ESD-J regarding the above incident with Resident 6. ESD-J stated, "Starting today I'm going to ride the elevator every day I'm here, to make sure it's running properly." ESD-J went on to say, "This is not a normal elevator, it's very different from your typical passenger elevator. My plan will be to train all staff, residents and families on how to use the elevator and document the training beginning today."

On 02/05/2025 at 2:20 PM, Surveyor interviewed Regional Director of Operations L and Operation Specialist B regarding the above incident. Both

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N 481	Continued From page 21 Regional Director of Operations L and Operations Specialist B verified the facility did not have an elevator policy and procedure or any documented staff training on the safety guidelines and proper usage of the elevator. Regional Director of Operations L stated, "We will be doing some elevator training now."	N 481		