STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014896	A. BUILDING: _____ B. WING _____	C 01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN HOME CARE LLC	1003 TAMARACK WAY VERONA, WI 53593

(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 01/03/2025, the bureau of assisted living Southern regional office conducted 2 complaint investigations at Evergreen Home Care LLC a CBRF located in Verona, WI. As a result of this survey, 4 violations of DHS Chapter 83 were issued. 2 complaints were substantiated. Census: 6	N 000		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. From 11/18/2019 to 01/04/2025, the provider did not comply with all the laws governing the CBRF as evidenced by 36 deficiencies and 8 substantiated complaints. FINDINGS INCLUDE: Facility is a Class CNA non-ambulatory with a capacity of 8 residents and serves irreversible dementia, Alzheimer's, emotionally disturbed, mental illness, advanced aged & physically disabled.	N 196		

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

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N 196	Continued From page 1 Example 1: Obtain and maintain compliance with laws governing the CBRF: On 11/18/2019, the bureau of assisted living Southern regional office conducted a standard survey and complaint investigation. As a result of the survey, 4 violations were identified in SOD 87Q611. The complaint was substantiated. 1.) 83.34(1) Limitations On Control Of Resident Funds 2.) 83.38(1)(g) Health Monitoring 3.) 83.38(1)(b) Smoke & Heat Detectors Per Nfpa 72- 4.) 83.48(3)(b) Sensitivity Testing Performed On 08/28/2020, the bureau of assisted living Southern Regional Office conducted 2 complaint investigations. As a result of the investigations, 2 violations were identified in SOD S2I511. Two of 2 complaints were substantiated. 1.) 83.32(3)(a) Rights of Residents: Communications 2.) 83.44(2)(a) Rooms Clean And Free From Odors On 07/20/2021, the bureau of assisted living Southern regional office conducted a complaint investigation. As a result of the investigation, 2 violations were identified in SOD ZBKC11. The complaint was substantiated. 1.) 83.12(4)(a) Reporting When Resident's Whereabouts Unknown 2.) 83.38(1)(b) Supervision On 06/02/2021, the bureau of assisted living Southern regional office conducted a verification visit and standard survey. As a result of the survey, 13 violations were identified in SOD S2I512. 1.) 83.28(5) Temporary Service Plan	N 196		

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N 196	Continued From page 2 2.) 83.35(3)(a) Comprehensive Individualized Service Plan 3.) 83.35(3)(b) Service Plan Development: Parties Involved 4.) 83.35(3)(d) Service Plans Updated Annually Or On Changes 5.) 83.35(4) Resident Satisfaction Evaluation 6.) 83.37(1)(e) Medication Regimen, Administration Review 7.) 83.38(1)(c) Leisure Time Activities 8.) 83.41(2)(c) Nutrition: Menus 9.) 83.41(3)(b) Food Safety 10.) 83.44(2)(a) Rooms Clean And Free From Odors 11.) 83.26(1)(c) Heating System Maintenance 12.) 83.47(2)(e) Other Evacuation Drills 13.) 83.47(4)(b) Fire Extinguishers Locations On 02/17/2022, the bureau of assisted living Southern regional office conducted a complaint investigation. As a result of the investigation, 2 violations were identified in SOD 44CE11. The complaint was substantiated. 1.) 83.29(3)(b) Admission Agreement Include Services, Changes 2.) 83.31(4)(c) involuntary Discharge Notice Requirements On 10/10/2023, the bureau of assisted living Southern regional office conducted a standard survey and 2 complaint investigations. As a result of this survey, 9 violations were identified in SOD R7W511. One of 2 complaints were substantiated. 1.) 83.12(4)(b) Reporting When Law Enforcement Is Called 2.) 83.31(4)(c) Involuntary Discharge Notice Requirements 3.) 83.35(3)(d) Service Plans Updated Annually 4.) 83.35(5)(b) Annual Evaluation Of Evacuation	N 196		

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N 196	Continued From page 3 Limits 5.) 83.38(1)(i) Behavior Management 6.) 83.42(1) Resident Record Maintained 7.) 83.43(1) Environment Safe, Clean, And Comfortable 8.) 83.43(2)(d) Clean Sheets, Pillowcases, And Towels 9.) 83.60(1) Total/openable Window Area On 01/04/2025, the bureau of assisted living Southern regional office conducted 2 complaint investigations. As a result, 4 violations were identified in SOD HHV511. Two of 2 complaints were substantiated. 1.) 83.14(2) Licensee Responsibilities 2.) 83.32(3)(i) Rights of Residents: Prompt & Adequate Treatment 3.) 83.35(3) Comprehensive Individualized Service Plan 4.) 83.43(1) Environment Safe, Clean, And Comfortable Example 2: Repeat violations of laws governing the CBRF. 1.) 83.31(4)(c) Involuntary Discharge Notice Requirements: SOD 44CE11 dated 02/17/2022 & SOD R7W511 dated 10/10/2023. 2.) 83.35(3)(a) Comprehensive Individualized Service Plan: SOD S2I512 dated 06/02/2021 & SOD HHV511 dated 01/04/2025. 3.) 83.43(1) Environment Safe, Clean, And Comfortable: SOD R7W511 dated 10/10/2023 & SOD HHV511 dated 01/04/2025. 4.) 83.44(2)(a) Rooms Clean And Free From Odors: SOD S2I511 dated 08/28/2020 & SOD S2I512 dated 06/02/2021.	N 196		

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N 196	Continued From page 4 Example 3: Number of Complaints Substantiated 1.) SOD 87Q611 dated 11/18/2019 - 1 complaint substantiated. 2.) SOD 52I511 dated 08/28/2020 - 2 complaints substantiated. 3.) SOD ZBKC11 dated 07/20/2021 - 1 complaint substantiated. 4.) SOD 44CE11 dated 02/12/2022 - 1 complaint substantiated. 5.) SOD R7W511 dated 10/10/2023 - 1 complaint substantiated. 6.) SOD HHV511 dated 01/04/2025 - 2 complaints substantiated. SUMMARY: The licensee did not ensure the facility and its operation complied with all laws governing the CBRF. The current survey included investigation of 2 complaints. As a result, 5 violations were identified, including 2 recited violations.	N 196		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure each resident received prompt and adequate treatment appropriate to the resident's needs.	N 353		

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Resident 1 did not receive adequate medical treatment to meet his/her needs. Resident 1 experienced a change of condition. After 12 days, Resident 1 was transported to the hospital and diagnosed with septic shock with multiorgan system failure, acute hypoxic respiratory failure, COVID infection, left sided pneumonia, collapse of the lung, multiple abrasions, wound(s) on his/her left & coccyx.

FINGINGS INCLUDE:

On 01/02/2025, The Department received a complaint regarding resident treatment at facility.

On 01/03/2025, Surveyor arrived at facility for a complaint investigation.

OBSERVATION:

On 01/03/2024 at 10:10 AM, Surveyor toured the facility with Licensee A. Licensee A identified Resident 1's room. Surveyor made the following observations in Resident 1's room and personal bathroom:
1.) The drywall directly above the head of the mattress was grossly stained with a black-gray colored substance (Picture 3).
2.) The bathroom sink, and counter were moderately stained with a pinkish-gray substance (Picture 4).
3.) The toilet, floor directly below the toilet, and the wall next to the toilet had small brown stains scattered on the surfaces (Picture 5).
4.) Gray hand shaped stains on the drywall directly above the back of the toilet (Picture 6).
5.) The toilet paper holder had been pushed through the drywall, which created 2 holes in the wall. The toilet paper holder mounting was

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hanging from the holes in the wall. Above the grab bar there was a gray-brown hand shaped stain on the drywall (Picture 7).
6.) A shelf in the bedroom which had approximately 26 full-sized Milky Way candy bars (Picture 8).

RECORD REVIEW:

On 01/03/2025, Surveyor reviewed Resident 1's facility face sheet. Resident 1 was admitted to the facility on 11/30/2021.

On 01/03/2025, Surveyor reviewed Resident 1's clinical aftercare summary, printed on 12/01/2021. Resident 1 was diagnosed with abnormal involuntary movement and memory loss on 06/19/2012, and Huntington's disease on 01/06/2015.

On 01/03/2025, Surveyor reviewed Resident 1's facility pre-admission assessment. The Pre-Admission Assessment was signed by Licensee A on 11/20/2021. The following was documented," Current diagnosis ... Huntington's disease ...Capacity for selfcare ... need Supervision ...supervision ...Yes ...Eating ...normal. Need watch to protect from choke ...Community contact ...Guardian ...Housekeeping ...Total Care ...Others fall risk ... [s/he] can walk by [himself/herself]. Need watch [him/her] and make sure not fall risk."

On 01/03/2025, Surveyor reviewed Resident 1's individualized service plan (ISP) dated 10/11/2024. The subsection titled, "physical disabilities" the following was documented, "None." The subsection titled, "Change in conditions/update," the following was documented, "08/10/2024 ...I found [him/her]

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walks slower than before. I also found [s/he] has confused sometime (sic.) ...I told [his/her] guardian ...I found [his/her] walking slower than before, and [s/he] has confused sometime (sic.). I told [name of guardian]. This caused by [his/her] Huntington (sic.)." The subsection titled, "Eating," the following was documented, "Staff total prepare eating independent ...encourage [him/her] to eat more and increase weight staff watch [his/her] eating to protect from choke." The subsection titled, "Grooming," the following was documented, "total care." The following was documented on the last page of the ISP under the 04/08/2024 signatures, "the nurse gives [his/her] physical check (O2, Blood pressure, pulse, hand and leg) it is normal. [His/her] mental is also normal. [no bad feeling, no bad behavior) ..." The following was documented under the 10/11/2024 signatures, "the physical condition is same. Short memory has little worse. nurse checked [him/her] ...BP=110/70 ..."

On 01/03/2024, Surveyor reviewed Resident 1's daily progress notes from 11/28/2024 to 12/17/2024:
-From 11/28/2024 to 12/03/2024, Resident 1 was documented as completely eating all 3 daily meals, breakfast, lunch, and dinner.
-On 12/04/2024, Resident 1 was documented as eating all his/her breakfast and lunch, but a small portion of dinner.
-On 12/05/2024 & 12/06/2024, Resident 1 was documented as eating all his/her breakfast, but only small portions of lunch and dinner.
-From 12/06/2024 to 12/08/2024, Resident 1 was documented as having an "occasional cough".
-On 12/10/2024, Resident 1 was documented as having an "occasional cough."
-From 12/07/2024 & 12/08/2024, Resident 1 was documented as only eating small portions of all 3

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daily meals.
-From 12/09/2024 to 12/11/2024, Resident 1 was documented as eating a majority of his/her 3 daily meals.
-On 12/14/2024, Resident 1 was documented as eating small portions of his/her 3 daily meals. A note signed by Licensee A documented, "I found [s/he] ate less than normal (I always watch his/her eating) I asked [him/her] and [s/he] said [s/he] isn't hungry I checked [his/her] room and found a lot sweets. [S/he] walked slower than before, but [s/he] still walks, no fall. When [s/he] walked around the house, I watched [him/her]. [S/he] smoked normal ..."
-On 12/17/2024, the following was documented, "at 11 :pm. [s/he] was weak and laid on [his/her] bed, but no drinking water (dehydration). So called 911 sent [him/her] to the ER."

On 01/03/2024 at 1:02 PM, Resident 1's Managed Care Organization (MCO) representative (MCO Representative E), emailed Surveyor Resident 1's, "Case Notes" dated from 12/19/2024 to 12/22/2024, and Resident 1's hospital discharge summary.

On 01/03/2024, Surveyor reviewed Resident 1's MCO case note documented by MCO Nurse F on 12/20/2024, "ASSESSMENT: PHYSICAL HEALTH: ...member is currently hospitalized after being found on the floor extremely weak in his/her room. Reports from EMS stated member had multiple areas of skin breakdowns and some redness in the bony areas. [Licensee A] reported that member had been declining hygienic cares ...Member was reported to be very frail. [Licensee A] reported member had been sick for a week and [his/her] not been eating as much as usual ...Member was taken by EMS to the ER and was admitted to the ICU (Intensive Care Unit) for

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acute respiratory failure and hypoxia ...Member's room was quite dirty, and bathroom appeared to have feces stains on the wall. Member's sheets were taken off to be washed after [s/he] was taken to the ER. The home appeared to be dirty throughout ..."

On 01/03/2025, Surveyor reviewed Resident 1's inpatient hospitalization discharge summary dated 12/20/2024. The following was documented, "Primary Discharge Diagnosis septic shock with multiorgan system failure ...Secondary Discharge Diagnoses acute hypoxic respiratory failure ... COVID infection ...left sided pneumonia ...Huntington's Disease ...Discharge Disposition ...Hospice ...Presenting Problem/History of Present Illness ...[Resident 1] ...admitted for flu-like symptoms and found to have collapse of left upper and lower lobes in addition to COVID pneumonia ...[Resident 1] normally resides in a group home and is nonverbal, history of Huntington's disease. For the past ? two weeks, [s/he] has reportedly not been feeling well and had had flu-like symptoms. Has not been eating or drinking and has been weaker than normal. EMS reports poor living quarters with concern for neglect. Noted to have soiled clothing, skin breakdown pressure wounds and overgrown nails ..." Under the subsection titled, "Hospital Course" wound care instructions for a wound to the left heel and coccyx were documented. On 12/19/2024, Resident 1's medical providers and family decided it was in Resident 1's best interest to discontinue curative treatment. Resident 1 was transferred from TLC service to palliative care service (comfort service). On 12/20/2024, Resident 1 was transferred from the hospital to an inpatient hospice unit (terminal illness service).

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N 353	Continued From page 10 On 01/03/2025, Surveyor reviewed police report #VE24-11292. Officer H documented the following, "After my phone call with [Officer I], I responded to the [Name of Hospital], where I spoke with the charge nurse. [S/he] verbally identified [himself/herself] as [Charge Nurse J]. [Charge Nurse J] advised [s/he] was told about the living conditions within the group home in which [Resident 1] resides. [S/he] described the home as poor and filthy, which is how it was described to [him/her] by [Name of EMS]. [Charge Nurse J] advised [Resident 1] had bed sores all over [his/her] body, some old and some new. [S/he] further explained that [s/he] is Covid positive, and [s/he] has been dealing with flu-like symptoms for over a week, which is why [s/he] is on a respirator while being in the ER. [Charge Nurse J] stated [Resident 1] was being admitted to the hospital from the ER because of [his/her] medical condition and because [s/he] clearly needs more medical treatment than the group home can provide to [him/her] ... [Charge Nurse J] explained Resident 1 is non-verbal so [s/he] is not able to talk to [him/her] about [his/her] injuries ...OFFICER'S OBSERVATIONS/ACTIONS I was advised [Resident 1] was in ER room #5. I entered [Resident 1's] room and identified myself. I observed [Resident 1] to be very thin. [His/her] fingernails and toenails were long and dirty. I observed several large sores on [his/her] body, to include both knees, left hip, right ankle, right elbow, and left forearm. I also observed an old injury to the top right side of [his/her] head, the left side of [his/her] nose and to the left of [his/her] left eye." Detective B documented the following, "On December 18, 2024, at 5:32 pm, I conducted a phone interview with [Lieutenant G]. [Lieutenant G] explained [s/he] responded to [address of facility] for a report of a sick person. [Lieutenant G] stated the [male/female] employee	N 353		

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there called because the patient had not eaten in a couple weeks and was feeling sick. [Lieutenant G] reported the following observations upon walking into room #2 and finding the patient, [Resident 1]: [Resident 1] was naked laying halfway on the bed and halfway off. The room was extremely dirty and unkept. The room smelled like urine and feces. The bed sheets were stained. The bed was extremely dirty. There were feces on the wall and floor in the bathroom. [Resident 1] was dirty and had not bathed in quite some time. [Resident 1's] fingernails and toenails were so long that they were curling back on themselves. [Resident 1] had scratches all over [himself/herself] with scabs at different stages of healing. Staff advised [Resident 1] was nonverbal. Staff provided EMS with a notebook with limited information on [Resident 1]. There was no mention of medication or medical conditions..."

INTERVIEW:

On 01/02/2025 at 1:10 PM, Surveyor spoke with Detective B. Detective B identified themselves as the detective assigned to an investigation at facility. Detective B stated EMS observed Resident 1 in his/her room naked and sitting half off the bed. EMS observed feces on the walls in the bathroom connected to Resident 1's bathroom. Detective B reported during his/her investigation, Licensee A stated Resident 1 had been walking around and smoking cigarettes the day before. Detective B reported EMS transported Resident 1 to an ER. Resident 1 was diagnosed with multiple pressure ulcers and small wounds. Detective B reported facility had 2 full-time staff, Licensee A and Caregiver C, and both staff worked alone for 12-hour shifts. Detective B reported Caregiver D rarely worked at

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facility. Detective B reported, Licensee A stated residents do not always receive medications and cares due to lack of staffing. Detective B reported the overall condition of the facility was not clean and/or well maintained.

On 01/03/2025 at 9:00 AM, Surveyor interviewed Licensee A. Surveyor asked Licensee A how s/he assessed other residents for COVID after s/he discovered Resident 1 was COVID positive. Licensee A stated s/he didn't notice any other residents having symptoms of COVID infection. Licensee A stated s/he did not have documentation related to COVID assessment(s) and/or prevention after being notified of a positive case in his/her facility. Licensee A explained when residents experienced a change in condition it was their facility policy to notify the resident's physician, activated power of attorney (APOA), and/or managed care organization (MCO) representatives. Licensee A reported s/he usually had a care team meeting with Resident 1's MCO representatives approximately every 3 months where s/he would report Resident 1's changes in condition and/or needs. Licensee A stated himself/herself and Caregiver C were the only staff who worked at the facility on a regular basis. Licensee A stated himself/herself and Caregiver C would be the individuals to assess resident changes in condition daily. Licensee A stated Resident 1's family had been very satisfied with the care Resident 1 had been provided by facility. Licensee A reported Resident 1 had been diagnosed with Huntington's disease and had refused medication/treatment for the disease. Licensee A reported s/he was aware Huntington's disease was considered a chronic condition with increasing disability. Licensee A reported Resident 1's appetite had been decreasing for approximately 2 years. Licensee A reported

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Resident 1 had been losing weight for the last couple of years. Licensee A reported Resident 1's family would bring food from home for facility to prepare and encourage him/her to eat. Licensee A reported Resident 1 had a 'sweet tooth' and s/he had been making sure his/her favorite candy bars were available in his/her room due to his/her decreased intake during meals. Licensee A reported Resident 1's decrease in appetite and weight had not been comprehensively assessed. Licensee A reported Resident 1 had a cigarette schedule, every 2 hours Resident 1 would request a cigarette from staff. Licensee A reported Resident 1 always had a "smokers cough." Licensee A reported Resident 1 had not been provided a comprehensive assessment of his/her cough. Licensee A acknowledged Resident 1 had been diagnosed as COVID positive when s/he had been transferred from the facility to the ER. Licensee A stated on 12/17/2024, Caregiver B was working at the time of the incident. Caregiver B heard a "thud" from Resident 1's room, Caregiver B went to his/her room, and found Resident 1 naked on the floor. Licensee A stated Caregiver B assisted Resident 1 to his/her bed and called 911. Licensee A reported Resident 1 would often refuse assistance with personal cares and nail cares. Licensee A reported Resident 1 had a habit of stripping off all his/her clothes upon entering his/her room. Licensee A reported s/he was not aware of Resident 1 having wounds and/or abrasions until after Resident 1 had been sent to the hospital.

On 01/03/2024 at 9:20 AM, Licensee A acknowledged Resident 1's bedroom had black stains on the wall, and brown stains on the surfaces around the toilet. Licensee A stated facility was in the process of hiring a housekeeper

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N 353	Continued From page 14 to clean the facility environment. Licensee A stated the Milky Way candy bars on the shelf were Resident 1's favorite. On 01/07/2025 at 2:45PM, Surveyor discussed the above incident with Licensee A. Licensee A acknowledged Resident 1 had not been provided adequate treatment for the flu-like symptoms s/he had been experiencing the weeks prior to being sent to the ER. Licensee A acknowledged Resident 1 did not receive adequate treatment from facility for the skin integrity issues assessed by ER on 12/17/2024. Licensee A acknowledged Resident 1 had not been provided a comprehensive assessment upon change in condition in December 2024. Licensee A acknowledged facility had been responsible for Resident 1's housekeeping and grooming. Licensee A acknowledged Resident 1's room and bathroom were not clean or of pleasant odor upon EMS arrival to facility on 12/17/2024. CROSS REFERENCE: N0196 DHS Chapter 83.14(2) Licensee Responsibilities CROSS REFERENCE: N0386 DHS Chapter 83.35(3) Comprehensive Individualized Service Plan CROSS REFERENCE: N0481 DHS Chapter 83.43(1) Environment Safe, Clean, And Comfortable	N 353		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan	N 386		

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shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not create a comprehensive individualized service plan (ISP) for Resident 1 which identified his/her needs, desired outcomes, program services the CBRF would provide, established measurable goals with specific time limits for attainment, specified methods for delivering care and who was responsible for delivering the care.

FINDINGS INCLUDE:

On 01/02/2025, The Department received a complaint regarding resident treatment at facility.

On 01/03/2025, Surveyor arrived at facility for a complaint investigation.

RECORD REVIEW

On 01/03/2025, Surveyor reviewed Resident 1's facility face sheet. Resident 1 was admitted to the facility on 11/30/2021.

On 01/03/2025, Surveyor reviewed Resident 1's clinical aftercare summary, printed on 12/01/2021. Resident 1 was diagnosed with

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abnormal involuntary movement and memory loss on 06/19/2012, and Huntington's disease on 01/06/2015.

On 01/03/2025, Surveyor reviewed Resident 1's facility pre-admission assessment. The Pre-Admission Assessment was signed by Licensee A on 11/20/2021. The following was documented," Current diagnosis ... Huntington's disease ...Capacity for selfcare ... need Supervision ...supervision ...Yes ...Eating ...normal. Need watch to protect from choke ...Community contact ...Guardian ...Housekeeping ...Total Care ...Others fall risk ... [s/he] can walk by [himself/herself]. Need watch [him/her] and make sure not fall risk."

On 01/03/2025, Surveyor reviewed Resident 1's individualized service plan (ISP) dated 10/11/2024. The subsection titled, "physical disabilities" the following was documented, "None." The subsection titled, "Change in conditions/update," the following was documented, "08/10/2024 ...I found [him/her] walks slower than before. I also found [s/he] has confused sometime (sic.) ...I told [his/her] guardian ...I found [his/her] walking slower than before, and [s/he] has confused sometime (sic.). I told [name of guardian]. This caused by [his/her] Huntington (sic.)." The subsection titled, "Eating," the following was documented, "Staff total prepare eating independent ...encourage [him/her] to eat more and increase weight staff watch [his/her] eating to protect from choke." The subsection titled, "Grooming," the following was documented, "total care." Zero, documentation regarding fall risk, abnormal involuntary movements and/or memory loss.

INTERVIEW:

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N 386	Continued From page 17 On 01/07/2024 at 2:45 PM, Surveyor discussed the above concern with Licensee A. Licensee A acknowledged Resident 1's ISP did not list his/her abnormal involuntary movements, fall risk, or specific information about his/her memory loss. Licensee A acknowledged Resident 1's ISP did not have specified information regarding his/her Huntington's disease. Licensee A acknowledged Resident 1's ISP did not document his/her pattern of refusal of hygienic cares and/or related interventions/specified goals. CROSS REFERENCE: N0196 DHS Chapter 83.14(2) Licensee Responsibilities CROSS REFERENCE: N0353 DHS Chapter 83.32(3)(i) Rights of Residents: Adequate Treatment CROSS REFERENCE: N0481 DHS Chapter 83.43(1) Environment Safe, Clean, And Comfortable	N 386		
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, record review, and interview, the provider did not ensure the CBRF provided a living environment that was safe, clean, comfortable, and homelike.	N 481		

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N 481	Continued From page 18 This was a repeat violation from statement of deficiency (SOD) RTW511 dated 10/10/2023. FINDINGS INCLUDE: On 01/02/2025, The Department received a complaint regarding the overall environment of the facility. On 01/03/2025, Surveyor arrived at facility for a complaint investigation. OBSERVATION: On 01/03/2024, Surveyor toured the facility with Licensee A. Surveyor made the following observations: 1.) A pinkish-yellow substance covered the basin of Resident 2's bathroom sink (Picture 9). 2.) The toilet and surfaces surrounding the toilet were splattered with yellowish-brown stains in Resident 2's bathroom (Picture 10). 3.) The vinyl floorboards in the main dining area had finish chipping from them throughout, some vinyl floorboards had gaps in-between them which allowed the vinyl floor boards to be movable. The damaged vinyl floorboards were causing an uneven walking surface in the main dining area (Picture 11 & Picture 15). 4.) The ceiling in the main dining area had large cobwebs hanging from all corners of the room (Picture 12). 5.) The kitchen faucet was moderately covered with a white mineral deposit-like substance (Picture 13). 6.) The large window in the main dining area had rust stains on the exposed metal framing (Picture 14). 7.) The resident shared bathroom had 1 bathtub. The bathtub had brown-orange substance on the	N 481		

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bottom. The bathtub jets had the brown-orange substance circling and flowing down the sides of the bathtub (Picture 1).
8.) The resident shared bathroom had 1 shower stall. The drywall tape directly above the shower stall was peeling from the drywall (Picture 2).

RECORD REVIEW:

On 01/03/2024, Surveyor reviewed police report #VE24-11292. Detective B documented the following, "On December 20, 2024, at approximately 10:00 am, I met with (representative's from Resident 1's managed care organization (MCO)) [MCO Nurse K] and [MCO Nurse F] ... We knocked on the door and met with one owner of [Name Of Facility] [Licensee A]. [Licensee A] was the only employee working at the time. I identified myself to [Licensee A]. {Nurse K] explained they were conducting an inspection. We conducted a walkthrough of the building, which consisted of eight rooms, a common living room area, a kitchen and dining room, a single shower/bathroom for all residents to share, and the basement. I took photos of the common living room area, [Resident 1's] room ..., [Resident 3's] room ..., [Resident 2's] room ..., and the shared shower/bathroom ... [Resident 1's] Room [Licensee A] said [s/he] was washing [Resident 1's] bedsheets so they were not present. [Resident 1's] bed had a mattress. [Resident 1's] bathroom had apparent feces on the walls, which included handprints, and splatter marks. The toilet was covered with feces. The sink area was extremely dirty. The toilet paper rolls on the sink counter had apparent feces on them ... [Resident 3's] Room [Resident 3] had a hospital style bed with a mattress. [Resident 3's] toilet had black mold or mildew in it. There were multiple empty

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cereal boxes and other empty food containers on the ground in the bathroom. There were some apparent feces on the outside of the toilet and on the floor of the bathroom ... [Resident 2's] Room [Resident 2's] bed had a box spring with no mattress. [Licensee A] said [Resident 2] preferred sleeping without a mattress. There were apparent feces on the outside of the toilet, on the floor of the bathroom, and covering the toilet brush. The sink was also dirty. Shared Shower / Bathroom [Licensee A] said [s/he] did not have a shower schedule for the residents, and [s/he] left it up to the residents when they wanted to shower. The shower was clean. The bath was grimy, but [Licensee A] said no one used the bath ..."

INTERVIEW

On 01/03/2024 at 11:45 AM, Surveyor discussed the above environmental concerns with Licensee A. Licensee A acknowledged Resident 1, Resident 2, and Resident 3's rooms were not cleaned and/or well maintained. Licensee A reported facility was responsible for the housekeeping in all resident rooms. Licensee A acknowledged the bathtub in the resident shared bathroom was dirty. Licensee A told Surveyor residents were not using the bathtub. Licensee A reported residents did not have access to a second clean bathtub. Licensee A acknowledged the bathtub was in a residential common space and would need to be kept well-maintained and clean in the future. Licensee A reported s/he was in the process of hiring a housekeeper. Licensee A acknowledged the damaged vinyl floorboards in the main dining area were damaged and had created an uneven walking surface, and would need to be repaired.

CROSS REFERENCE: N0196 DHS Chapter

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N 481	Continued From page 21 83.14(2) Licensee Responsibilities CROSS REFERENCE: N0353 DHS Chapter 83.32(3)(i) Rights of Residents: Adequate Treatment CROSS REFERENCE: N0386 DHS Chapter 83.35(3) Comprehensive Individualized Service Plan	N 481		