| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 0015882 | A. BUILDING: _____ B. WING _____ | C 09/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HANNAHS HOUSE WEST | 510 N GAMMON MADISON, WI 53717 |

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| N 000 | Initial Comments<br><br>On 09/23/2024, Surveyors conducted a complaint investigation at Hannahs House West.<br><br>Seven deficiencies were identified.<br><br>Two of 7 deficiencies were repeat violations. See Statement of Deficiencies (SOD) EZB311, dated 04/04/2023, S6VU11, dated 10/26/2021, and SOD RFQT13, dated 01/27/2021.<br><br>The complaint was substantiated.<br><br>Census: 7 | N 000 | | |
| N 214 | 83.15(3)(a) Administrator shall supervise daily operation<br><br>The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, Administrator C did not supervise daily operations of the CBRF by allowing staff to bring their children to work. Cares, meals, and medications were delayed while House Manager A and Caregiver B brought their children to work including for overnights. | N 214 | | |

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

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| N 214 | Continued From page 1<br><br>Findings include:<br><br>On 07/19/2024, the Department received a complaint alleging concerns staff were bringing their children to work.<br><br>On 09/23/2024, Surveyor conducted a complaint investigation. The following was found:<br><br>On 09/23/2024 at 8:50 AM upon entering the facility, Surveyor observed a baby in a car seat on top of the kitchen table. The baby was being comforted by Resident 6. House Manager A stated the baby was his/her infant son/daughter. House Manager A stated Administrator C allowed staff to bring their children to work as daycare prices were very high. House Manager A stated s/he worked the 3rd shift last night with the baby. Surveyor observed House Manager A assist residents in their rooms and do other job responsibilities throughout the home while leaving his/her baby with residents. By 9:30 AM, Caregiver B arrived to the facility and took House Manager A's position so s/he could go home with their baby.<br><br>On 09/23/2024 at 9:05 AM and 11:05 AM, Surveyor interviewed Resident 6. Resident 6 stated s/he had lived at the facility for 7 weeks and saw House Manager A or Caregiver B bring their children multiple days of the week. Resident 6 stated House Manager A and Caregiver B were married and had 3 children that all came to work at different times. Resident 6 stated the other children were 3 and 6 years old. Resident 6 stated the baby, Surveyor observed this morning had spent the night with House Manager A. Resident 6 stated s/he liked seeing children, but 1 time when coming out to use the bathroom during | N 214 | | |

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| N 214 | Continued From page 2 | N 214 | | |

the night, s/he almost rolled over a sleeping child's arm with their walker. Resident 6 stated it was dark and hard to see, but luckily s/he saw the child's arm just in time.

On 09/23/2024 at 10:01 AM, Surveyor interviewed Resident 1. Resident 1 confirmed children were often at the facility. Resident 1 stated House Manager A and Caregiver B bring their children to work because of daycare costs. Resident 1 reported House Manager A 's baby stayed last night into the morning.

On 09/23/2024 at 11:20 AM, Surveyor interviewed Resident 2. Resident 2 stated House Manager A's and Caregiver B's children were brought to the facility at least 4 days/week. Resident 2 stated medications and meals are often delayed because staff are caring for their children instead of the residents. Resident 2 stated the children will play in the only resident bathroom on the main level, and residents have to wait until their done to use the bathroom. Resident 2 noted staff will lock the front door to keep their children from getting out and residents have gotten locked out of the facility when going out for a cigarette. Resident 2 stated s/he felt like s/he had no privacy when the children were running around the facility. Resident 2 stated s/he had brought the concerns to Administrator C but s/he does not do anything about it.

On 09/23/2024 at 12:55 PM, Surveyors interviewed Administrator C regarding staff bringing their children to work. Administrator C stated s/he allowed staff to bring their children to work because it gave the residents emotional support. Surveyor asked if Resident 2 had brought concerns forward about children at the facility. Administrator C confirmed s/he was

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| N 214 | Continued From page 3<br>aware House Manager A and Caregiver B brought their children due to high day care costs but was unaware the children spent the night. Surveyor expressed concern medications and meals were delayed because staff were caring for their children instead of the residents. Surveyor shared concern about Resident 6 almost running over a child's arm with their walker. Administrator C acknowledged the concern but continued to ask what parameters existed so staff could continue to bring their children. | N 214 | | |
| N 352 | 83.32(3)(h) Rights of Residents: Receive medication<br><br>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview, and record review, the provider did not ensure 2 of 3 residents reviewed received all prescribed medications in the dosage and intervals prescribed by the physician.<br><br>Resident 1 did not receive all his/her scheduled medication from the dates 09/07/2024 - 09/22/2024.<br><br>Resident 3 did not receive all his/her scheduled medication from the dates 09/20/2024 - 09/22/2024.<br><br>This is a repeat violation. See Statement of | N 352 | | |

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| N 352 | Continued From page 4<br>Deficiency (SOD) S6VU11, dated 10/26/2021.<br><br>Findings include:<br><br>On 09/23/2024 at 9:10 AM, Surveyor observed the provider's medication cart with House Manager A. Surveyor identified medication for Resident 1 and Resident 3 that had previous doses still in the medication packaging. Surveyor asked House Manager A why the medications were not given. House Manager A stated it could have been that the resident was out of the facility. S/he checked the calendar and found no evidence that either resident identified had been out of the facility during the missed doses of medication. House Manager A stated that Resident 1 had been out of his/her bedtime medication, which s/he believed was making him/her refuse other medication. House Manager A stated Resident 3 frequently refused medications and would sleep past the 1-hour mark of when each medication could be administered.<br><br>On 09/23/2024 at 10:35 AM, Surveyor interviewed Caregiver B. Caregiver B stated s/he was aware of Resident 1 refusing medications.<br><br>On 09/23/2024, Surveyor reviewed resident records which documented:<br><br>Example 1- Resident 1<br><br>Resident 1 admitted to the facility on 07/12/2024 with diagnosis including heart failure, hypertension, type 2 diabetes, hyperlipidemia, polyneuropathy, and dementia. Resident 1 had an activated healthcare power of attorney (AHPOA) that made decisions on his/her behalf. | N 352 | | |

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| N 352 | Continued From page 5<br>Resident 1's individual service plan (ISP), dated 09/04/2024, did not document him/her refusing medication.<br><br>Resident 1's medication administration record (MAR) included orders for the following:<br>"Amiodarone 200 mg tablet- Take 1 tablet by mouth daily- Scheduled for 8:00 AM.<br>Carvedilol 3.125 mg tablet- Take 1 tablet by mouth twice daily with meals- Scheduled for 8:00 AM and 5:00 PM.<br>Furosemide 20 mg tablet- Take 1 tablet by mouth every morning- Scheduled for 8:00 AM.<br>Gabapentin 100 mg capsule- Take 2 capsules by mouth three times daily- Scheduled for 8:00 AM, 2:00 PM, and 8:00 PM.<br>Hydrocort 10 mg tablet- Take 1 tablet (10mg) by mouth every morning and ½ tablet (5mg) daily at 2pm- Scheduled for 8:00 AM."<br><br>Surveyor identified the following medication was not administered to Resident 1 as prescribed:<br><br>Amiodarone- Morning: 09/18<br>Carvedilol-Morning: 09/18<br>Carvedilol- Supper: 09/07, 09/15, 09/17<br>Furosemide- Morning: 09/18<br>Gabapentin- Morning: 09/18<br>Gabapentin- Afternoon: 09/21, 09/22<br>Gabapentin- Evening: 09/07, 09/15, 09/17, 09/22<br>Hydrocort- Morning: 09/18<br>Hydrocort- 2:00 PM: 09/06 - 09/13, 09/15, 09/16, 09/18 - 09/20<br>Vitamin B-6- Morning: 09/16, 09/22<br><br>The medications listed above were documented as administered on the MAR for all the above times and dates. No special notes or exceptions were entered into Resident 1's MAR. | N 352 | | |

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| N 352 | Continued From page 6<br>Example 2- Resident 3<br><br>Resident 3 admitted to the facility on 02/02/2012 with diagnosis including diabetes, hyperlipidemia, anxiety, and depression. Resident 3 is their own legal decision maker.<br>Resident 3's ISP, dated for 02/02/2023 and 02/02/2024, did not document him/her refusing medication.<br><br>Resident 3's medication administration record (MAR) included orders for the following:<br><br>"Aripiprazole 5 mg tablet- Take one tablet by mouth once daily- Don't crush- Scheduled for 8:00 AM.<br>Aspirin 81 mg tablet- Take one tablet by mouth once daily- Don't crush- Scheduled for 8:00 AM.<br>Atorvastatin 20 mg tablet- Take one tablet by mouth once daily- Scheduled for 8:00 AM.<br>Duloxetine 60 mg capsule- Take one capsule by mouth once daily- Don't crush- Scheduled for 8:00 AM.<br>Folic Acid 400 mcg tablet- Take two tablets (800 mcg) by mouth daily- Scheduled for 8:00 AM.<br>Furosemide 20 mg tablet- Take one tablet by mouth once daily- Scheduled for 8:00 AM.<br>Gabapentin 300 mg capsule- Take one capsule by mouth once daily at bedtime- Don't crush- Scheduled for 8:00 PM.<br>Lisinopril 5 mg tablet- Take one tablet by mouth once daily- Scheduled for 8:00 AM.<br>Loratadine 10 mg- Take one tablet by mouth once daily- Scheduled for 8:00 AM.<br>Metformin 500 mg tablet- Take 1 tablet by mouth once daily in the evening with dinner- Don't crush- Scheduled for 4:00 PM.<br>Omeprazole 40 mg capsule- Take once capsule by mouth twice daily before breakfast and supper- Don't crush- Scheduled for 8:00 AM and | N 352 | | |

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| N 352 | Continued From page 7<br>4:00 PM.<br>Vitamin B-12 1000 mcg tablet- Take one tablet by mouth once daily- Scheduled for 8:00 AM."<br><br>Surveyor identified the following medication was not administered to Resident 3 as prescribed:<br><br>Aripiprazole- 8:00 AM: 09/21 and 09/22<br>Aspirin- 8:00 AM: 09/21 and 09/22<br>Atorvastatin- 8:00 AM: 09/21 and 09/22<br>Duloxetine- 8:00 AM: 09/21 and 09/22<br>Folic Acid- 8:00 AM: 09/21 and 09/22<br>Furosemide- 8:00 AM: 09/21 and 09/22<br>Gabapentin- 8:00 PM- 09/20, 09/21, 09/22<br>Lisinopril- 8:00 AM: 09/21 and 09/22<br>Loratadine- 8:00 AM: 09/21 and 09/22<br>Metformin- 4:00 PM: 09/20, 09/21, and 09/22<br>Omeprazole- 8:00 AM: 09/21 and 09/22<br>Omeprazole- 4:00 PM: 09/20, 09/21, and 09/22<br>Vitamin B-12- 8:00 AM: 09/21 and 09/22<br><br>The medications listed above were documented as administered on the MAR for all the above times and dates. No special notes or exceptions were entered into Resident 3's MAR.<br><br>On 09/23/2024 at 11:05 AM, Surveyor interviewed Resident 3. Resident 3 stated s/he had no concerns with his/her medication administration completed by facility staff. Resident 3 stated s/he took all medication staff administered to him/her and s/he did not refuse to take medication. Surveyor showed Resident 3 the medication doses that were not administered to him/her. Resident 3 then stated sometimes the staff forget, as they get very busy. Resident 3 also stated staff sometimes would not wake him/her up to take his/her medication and when s/he woke up on his/her own, it would be passed the medication administration time frame so the staff | N 352 | | |

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| N 352 | Continued From page 8<br>would not administer it.<br><br>On 09/23/2024 at 11:16 AM, Surveyor interviewed Resident 1. Resident 1 stated s/he had no concerns with his/her medication administration completed by facility staff. S/he reported staff bring his/her medication routinely and that s/he did not refuse medications. Surveyor showed Resident 1 the missed medication doses that were discovered. Resident 1 then stated sometimes s/he is out of the facility, so s/he might have missed medication during those times. Resident 1 stated s/he would often sit out back on the lower-level patio which had caused staff to miss administration of his/her medications on several occasions.<br><br>On 09/23/2024 at 12:00 PM, Surveyor interviewed Administrator C. Administrator C stated s/he was not aware of Resident 1 and Resident 3 refusing medications. Surveyor shared the responses of Resident 1 and Resident 3. Administrator C stated s/he could see the problem when staff had not asserted more effort to find or wake residents for medication administration. Surveyor asked about documentation on the MAR, as it did not match the medication being stored. Administrator C stated staff should have been marking with a circle and adding a note when there was a medication administration exception. Administrator C stated s/he would work with staff on improving MAR documentation, putting stronger effort into medication administration, and protocol for administering medication outside of the scheduled time frame. | N 352 | | |
| N 387 | 83.35(3)(b) Service plan development: parties involved | N 387 | | |

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| N 387 | Continued From page 9<br><br>Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure all Individual Service Plans (ISP) had been signed by the responsible parties. Three of 3 resident records reviewed did not contain the required signatures.<br><br>Findings include:<br><br>On 09/23/2024, Surveyor reviewed resident records and identified the following:<br><br>Resident 1 admitted to the facility on 07/12/2024 with diagnosis including heart failure, hypertension, type 2 diabetes, hyperlipidemia, polyneuropathy, and dementia. Resident 1 had an activated healthcare power of attorney (AHPOA) that made decisions on his/her behalf. Resident 1's ISP, dated 09/04/2024, was not signed by | N 387 | | |

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| N 387 | Continued From page 10<br>Resident 1's AHPOA.<br><br>Resident 2 admitted to the facility on 02/01/2024 with diagnosis including major depressive disorder, generalized anxiety disorder, panic disorder, epilepsy, and alcoholic cirrhosis of liver. Resident 2 had a guardian that made decisions on his/her behalf. Resident 2's ISP dated 3/22/2024, did not include a signature from Resident 2's guardian.<br><br>Resident 3 admitted to the facility on 02/02/2012 with diagnosis including diabetes, hyperlipidemia, anxiety, and depression. Resident 3 is their own legal decision maker. Resident 3's record did not contain an updated ISP with a signature from Resident 3. The ISP from 2023, had a small note written on the top which indicated the ISP had been reviewed in September of 2024. There were no notes within the ISP about changes, and there was not a new signature obtained from Resident 3.<br><br>On 09/23/2024 at 12:54 PM, Surveyors interviewed Administrator C about ISPs for Residents 1, 2, and 3. Administrator C stated s/he believed s/he had obtained a signature from Resident 2's AHPOA, but s/he could be thinking of the admission agreement, which was signed and in Resident 2's record. Administrator C stated s/he would obtain signatures for the residents who needed them. | N 387 | | |
| N 409 | 83.37(1)(j) Proof-of-use record.<br><br>Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that | N 409 | | |

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| N 409 | Continued From page 11<br>contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure all schedule II drugs were audited on a daily basis. Resident 1's Oxycodone, scheduled for as needed use, was not audited daily.<br><br>Findings include:<br><br>On 09/23/2024 at 9:29 AM, Surveyor reviewed the provider's schedule II drugs and daily audits. Resident 1 had an order for the following: "Oxycodone Hcl 5 Mg Tab- Take 1 tablet by mouth every 6 hours as needed for pain. Start Date: 07/18/2024."<br><br>The provider's log of Resident 1's Oxycodone audits, dated 07/20/2024, did not include audits for the following days:<br><br>07/21/2024 - 07/23/2024<br>07/25/2024 - 08/02/2024<br>08/04/2024 - 08/05/2024<br>08/10/2024 - 08/15/2024<br>08/18/2024 - 08/25/2024<br>08/27/2024 - 09/05/2024<br>09/07/2024 - 09/22/2024<br><br>On 09/23/2024 at 9:30 AM, Surveyor interviewed House Manager A. House Manager A stated they don't count Resident 1's Oxycodone regularly | N 409 | | |

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| | 0015882 | A. BUILDING: _____ B. WING _____ | C 09/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| N 409 | Continued From page 12<br>because it is not used regularly, so the count remains the same.<br><br>On 09/23/2024 at 12:54 AM, Surveyors interviewed Administrator C. Surveyor asked why Resident 1's Oxycodone was not being counted daily. Administrator C stated s/he was not sure what happened, that they must have fallen out of the habit. Administrator C states s/he knows this regulation and will get staff back on track with the daily audit. | N 409 | | |
| N 481 | 83.43(1) Environment safe, clean, and comfortable<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure the living environment was clean and homelike.<br><br>This violation is being cited for the 3rd time. See Statement of Deficiency (SOD) EZB311, dated 04/04/2023, and SOD RFQT13, dated 01/27/2021.<br><br>Findings include:<br><br>On 09/23/2024, Surveyor toured the facility and observed the following:<br><br>At 9:26 AM, Surveyor observed a large hole in the | N 481 | | |

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| N 481 | Continued From page 13 | N 481 | | |

ceiling of the staff office. The drywall was cracked and insulation could be seen hanging down.

At 9:27 AM, in the entryway of the home, observed a floor vent bent inwards and rusted. The closet door next to the entrance had a hole the size of a golf ball.

At 9:28 AM, in the hallway leading to resident rooms on the main floor, 1 wall had discolored paint.

At 9:29 AM, in the kitchen, observed wires near the ceiling that were coming out of a cord hider.

At 9:31 AM in Resident 4's bathroom sink, observed soap scum build up and a layer of dirt and hair. The wall next to the vanity mirror was covered in a thick layer of dust.

At 9:54 AM, the basement common area had many stains throughout the carpet. The smoke detector attached to the ceiling was hanging down.

At 10:02 AM, the basement shower basin had soap scum build up and a layer of dirt and hair.

At 10:03 AM, Resident 5's bedroom carpet had many stains throughout the carpet.

At 10:04 AM, the basement hallway leading to resident rooms, the ceiling was discolored and appeared to have a layer of drywall mud.

At 11:28 AM, the hallway to the right of the front door, had chips and holes in the drywall. There was long black marks going the length of the wall.

On 09/23/2024 at 12:55 PM, Surveyors

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| N 481 | Continued From page 14<br>interviewed Administrator C regarding the condition of the environment. Administrator C acknowledged the facility needed updates, but noted a new roof was recently added. Administrator C stated s/he would work with staff to address the above concerns. | N 481 | | |
| N 499 | 83.45(3) Toxic substances.<br><br>Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were stored in a secured area.<br><br>Findings include:<br><br>The provider is licensed as a class AA (ambulatory) CBRF (community-based residential facility) able to serve up to 8 residents in the following client groups: advanced age, irreversible dementia/Alzheimer's, and emotionally disturbed/mental illness.<br><br>On 09/23/2024 at 9:26 AM-11:28AM, Surveyor toured the facility and observed the following:<br><br>-In Resident 4's bathroom, 1 spray bottle of Lysol all purpose cleaner.<br><br>-In the basement bathroom, 1 bottle of toilet bowl cleaner, 2 spray bottles of all purpose cleaner.<br><br>-In the basement storage room, 2 spray bottles of | N 499 | | |

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| N 499 | Continued From page 15<br>Lysol all purpose cleaner, 1 bottle of Comet cleaner, and 2 spray bottles of bleach bathroom cleaner.<br><br>-In the main floor bathroom, 2 spray bottles of Oxi-clean cleaner and 1 bottle of toilet bowl cleaner.<br><br>-Under the kitchen sink, 2 spray bottles of bleach cleaner, 2 spray bottles of Windex, and 1 bottle of Dawn dish detergent.<br><br>-Open area next to kitchen sink, 1 large bottle of Clorox bleach solution.<br><br>On 09/23/2024 at 12:55 PM, Surveyors interviewed Administrator C regarding toxic substances not being secured. Surveyor shared 6 locations in the home had toxic substances that were not secured. Administrator C acknowledged an understanding of the concern. Administrator C stated s/he would address the concern with staff. | N 499 | | |
| Y3234 | 50.09(1)(e) Treatment<br><br>(1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to:<br><br>(e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. | Y3234 | | |

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 7 was treated with courtesy, respect, and full recognition of his/her dignity by all employees of the facility with whom the resident comes in contact.

Findings include:

On 07/19/2024, the Department received a complaint alleging mistreatment from staff.

On 09/23/2024, Surveyor conducted a complaint investigation. The following was found:

On 09/23/2024 at 9:45 AM, Surveyor interviewed Resident 2 regarding staff mistreatment. Resident 2 stated Caregiver D can be mean towards residents. Resident 2 stated on 07/20/2024 s/he heard Caregiver D yelling at Resident 7 from his/her room. Resident 2 stated s/he recorded the altercation from his/her bedroom with the door cracked open. Resident 2 showed the Surveyor the video on his/her cellphone.

Surveyor reviewed the video/audio file dated 07/20/2024 at 12:38 PM and the following was identified:
"Caregiver D stated on the video, "I told you to sit on the couch. Stay the [expletive] where you are. Stay where I told you to stay, then we wouldn't have a problem. You're being a problem. If you would stay where you are, then it would be fine. No, you are going to stay here. You're going to stay right here, like I told you. You're going to stay

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sitting." Resident 7 then stated, "I don't want too." Caregiver D replied, "Because thieves break the rules." Resident 7 stated, "I don't want to live here." Caregiver D stated, "That's not up to me, that's up to your [brother/sister]. You're going to sit here until you stop being a thief." Resident 7 stated, "I'm not a thief." Caregiver D stated, "You are one, you have stolen so many people's things and you're going to stop or you're going to sit here all day. Ah, I said sit here. [Resident 7] no, you're going to sit here, and sit here, you're going to sit here until you stop being a thief." Resident 7 stated, "I'm not one." Caregiver D stated, "Sit right here, because you are one, you stole my cup earlier today. You stole someone's stuff just last week." Resident 7 stated, "bull [expletive]." Caregiver D stated, "It's true, stop, I told you to stay out of the kitchen, you do it anyway and you're going to sit right here. I can stay right here all day. I don't know why you're moving your arm, it takes little to no effort. I care about the fact that you're stealing other residents' things. Everything in that kitchen doesn't belong to you. You already did. Actions have consequences. These are your consequences. You already did." Resident 7, "asks for a cigarette." Caregiver D replied, "It's not cigarette time. You don't get to grab them, there in a locked box, that you don't have a key to. So, you need to stay out of the kitchen, when you stop stealing other peoples' things you can get up and go to your room. But for now, you're going to sit in the living room so I can keep an eye on you. Because you keep stealing, I'm not going to keep arguing with you, I see you do it [Resident 7]. Your [brother/sister] doesn't live in the state, you can't keep using that as an excuse. You need to stop being a thief. Until you stop being a thief, you're going to sit right here, so I can watch you. [Resident 7] what did I just say. Sit right here so I can watch you, so you won't

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steal anything else."

On 09/23/2024 at 11:20 AM, Surveyor interviewed Resident 2. Resident 2 stated s/he informed Administrator C about Caregiver D yelling at Resident 7 and how s/he treated me as well. Resident 2 stated Administrator C will not do anything about it because s/he does not want to lose staff. Resident 2 stated Resident 7 would often steal items from resident rooms or the refrigerator. Resident 2 stated Resident 7 passed away in August 2024.

On 09/23/2024, Surveyor reviewed Resident 7's limited record. Resident 7 admitted to the facility on 05/17/2016. Resident 7 passed away in August 2024. The record did not contain any information related to Resident 7's altercation with Caregiver D on 07/20/2024.

On 09/23/2024 at 12:55 PM, Surveyors interviewed Administrator C regarding Resident 7's altercation with Caregiver D on 07/20/2024. Surveyor played the video/audio file and Administrator C confirmed Caregiver D was the staff in the video and Resident 7 was the resident in the video. Administrator C stated s/he was aware of Caregiver D having an attitude with Resident 2 in the past and s/he was talked with, but nothing was documented about it. Administrator C stated s/he was unaware of the above altercation and would have immediately investigated. Administrator C denied Resident 2 reporting to him/her about the altercation between Resident 7 and Caregiver D. Administrator C stated Caregiver D put his/her 2 weeks' notice in, and only had 1 week left of employment. Surveyor expressed concern regarding staff treatment of the residents. Administrator C acknowledged an understanding of the concern

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| Y3234 | Continued From page 19<br>and stated it was out of line for Caregiver D to talk to Resident 7 in the way s/he did on the video. Administrator C noted the provider would start their own investigation into the recording of Resident 7 from 07/20/2024 and ensure no other residents were affected. | Y3234 | | |