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{N 000}	Initial Comments On 05/07/2024, Surveyors completed a verification visit, complaint investigation (x6), and a self-reports investigation (x4). Data collected through 05/15/2025. Five of 6 complaints were substantiated. Seven deficiencies were identified. Five deficiencies were repeat violations. See Statement of Deficiency (SOD) 8WZX12, dated 07/23/2021, SOD H7LH11, dated 04/07/2022, and SOD J0PF11, dated 10/06/2023. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 32	{N 000}		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any	N 239		

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

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N 239	Continued From page 1 employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 employees (Caregiver E and Caregiver H) obtained all department approved training as required. Caregiver E and Caregiver H, who had responsibilities for medication administration, did not have training in medication administration and management prior to assuming these duties. Findings include: This is a repeat violation. See Statement of Deficiency (SOD) 8WZX12, dated 07/23/2021, and SOD J0PF11, dated 10/06/2023. The department received complaints regarding caregivers passing medications without proper training. On 05/07/2025, Surveyor conducted a review of 2 employees to verify compliance with department approved training requirements. Surveyor also requested staff schedules from 2/23/2025-present. Medication Administration The record for Caregiver E, hired 08/29/2024, did not contain evidence of training or evidence of	N 239		

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N 239	Continued From page 2	N 239		

meeting an exemption for medication administration. On 05/15/2025 at approximately 10 AM, Surveyor interviewed Director of Operations (DOO) A and Administrator B. DOO A confirmed Caregiver E was responsible for medication administration duties.

On 05/07/2025, Surveyor verified Caregiver E was not on the Community-Based Care and Treatment training registry for medication administration until 03/18/2025.

Caregiver E was on the schedule as a medication (med) passer on 2/24/2025 and worked as a med passer 5 additional times until s/he took his/her medication administration class on 03/18/2025.

The record for Caregiver H, hired 02/10/2025, did not contain evidence of training or evidence of meeting an exemption for medication administration. On 05/15/2025 at approximately 10 AM, Surveyor interviewed Director of Operations (DOO) A and Administrator B. DOO A confirmed Caregiver H was responsible for medication administration duties.

On 05/07/2025, Surveyor verified Caregiver H was not on the Community-Based Care and Treatment training registry for medication administration until 03/11/2025.

On 05/12/2025 at approximately 3:05 PM, Surveyor interviewed Caregiver H. Caregiver H stated, "I've been passing meds since I started".

On 05/15/2025 at approximately 10 AM, Surveyor interviewed DOO A, Administrator B, and Care Coordinator (CC) J. DOO A stated there was a "short time frame" Caregiver E and H were passing medications but not on the registry. DOO

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N 239	Continued From page 3 A stated that Administrator B completed medication administration training for Caregiver E and H but did not get them on the registry. Administrator B stated s/he realized that his/her certification was expired which is why s/he could not get them entered the system. Administrator B stated, "It was my fault I didn't check into and realize that."	N 239		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and	N 247		

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N 247	Continued From page 4 transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 employees obtained all task specific training. Caregiver C, Caregiver D, and Caregiver E, who perform dietary duties, did not have training in dietary services within 90 days after assuming these job duties. Findings include: This is a repeat deficiency. See Statement of Deficiency (SOD) J0PF11, dated 10/06/2023. On 04/10/2025, the department received a complaint related to the provider's dietary program. On 05/07/2025, at approximately 9:30 AM, Surveyor interviewed Caregiver C. Caregiver C stated there was not a cook on Tuesday, Wednesday, and Thursday. Caregiver C stated care staff were responsible for meals on those days. Caregiver C stated NOC (overnight) shift caregivers would often prepare the food and housekeeping staff would help prepare and serve the food during the day.	N 247		

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N 247	Continued From page 5 At approximately 10:00 AM, Surveyors interviewed Director of Operations (DOO) A and Administrator B. When asked about staffing roles and responsibilities, Administrator B stated they employed a full time cook. The cook was scheduled on Friday, Saturday, Sunday, and Monday. Caregiver G was identified as the cook on the staff roster. Administrator B stated they planned to hire a second cook and staff would prepare meals on the days when the cook was not scheduled. Administrator B stated staff scheduled on the second shift would typically prepare meals. At approximately 11:30 AM, Surveyor observed Caregiver D in the kitchen area supporting residents in the preparation of the noon meal. At approximately 1:10 PM, Surveyor conducted a review of 4 employees to verify compliance with task specific training requirements. Surveyor requested training records from DOO A and Administrator B for Caregiver C, Caregiver D, Caregiver E and Caregiver F. Dietary Training The record for Caregiver C, hired on 12/31/2024, did not contain evidence of training or evidence of meeting an exemption for dietary training. The record for Caregiver D, hired on 04/22/2024, did not contain evidence of training or evidence of meeting an exemption for dietary training. The record for Caregiver E, hired on 08/29/2024, did not contain evidence of training or evidence of meeting an exemption for dietary training. At approximately 1:30 PM, Surveyor interviewed DOO A. When asked to confirm the employees	N 247		

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N 247	Continued From page 6 date of hire, DOO A stated the employee orientation date was considered the employee's date of hire. When asked about evidence of dietary training completed by staff, DOO A stated that any training staff had completed would be in their designated file folder. Surveyor reviewed file folders referenced by DOO A. Caregiver C, Caregiver D, and Caregiver E's records each included a document titled, "Employee Training Record." There was a section titled, "Dietary Training," that indicated the training was designated to take 2 hours to complete. The section was blank on the 3 employee training records. When asked why the 3 areas were blank, DOO A stated they kept the dietary training documentation in a different area. Surveyor requested that documentation. DOO A stated s/he would send it to Surveyor via email. At 1:33 PM, Surveyor received an email from DOO A. The email contained a document titled, "Dietary Needs Training." The document appeared to be a curriculum guide to dietary training and was 14 pages long. It did not include the names of staff who took the training, the date the training was received, or the length of time it took to complete the training. On 05/15/2025, at approximately 10:30 AM, Surveyors interviewed DOO A and Administrator B via Teams meeting. Surveyor shared concerns regarding staff training of dietary procedures. DOO A stated the provider tried to limit the number of staff that worked in the kitchen. DOO A stated all staff were responsible for serving food to residents and not all staff had to cook.	N 247		
N 354	83.32(3)(j) Rights of Residents: Treatment options	N 354		

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N 354	Continued From page 7 In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Treatment options. Participate in the planning of care and treatment, be fully informed of care and treatment options and have the right to refuse any form of care or treatment unless the care or treatment has been ordered by a court. This Rule is not met as evidenced by: Based on interview and record review, the facility did not allow a resident or resident's legal representative to participate in the planning of care and treatment, be fully informed of care and treatment options, and have the right to refuse any form of care or treatment unless the care or treatment has been ordered by a court, for Resident 5. Findings include: The department received a complaint regarding the provider not following a resident's choice in code status. On 05/07/2025 at approximately 11 AM, Surveyors interviewed Registered Nurse (RN) I about how things had been going since s/he started at the provider the end of March. RN I explained that there were some policies that still needed to be created or smoothed out. RN I explained that the cardiopulmonary resuscitation (CPR) policy was one of those. RN I stated that when s/he started, s/he asked Director of Operations (DOO) A and Administrator B about the process for CPR at the facility, to which they stated, "I'll leave that up to you." RN I explained that the facility recently had a situation that led him/her to audit all residents'	N 354		

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N 354	Continued From page 8 charts regarding their code status. RN I explained they recently had a resident who coded. RN I stated that their computer system had a ring around each resident that was either green or red. Green indicated full code, red meant DNR (do not resuscitate). In this instance the computer showed full code, but the resident was in fact a DNR. RN I stated that this led them to audit their system regarding code status. S/he stated that they found a few different issues when the audit was performed. Some residents were found to not have code paperwork in their chart. They also found that some additional residents had the wrong code status noted in the computer system. RN I stated s/he did audit all charts after this incident, however, there had been no official policy implemented after this incident. On 05/07/2025 at approximately 1:10 PM, Surveyor requested Resident 5's record from Administrator B, including his/her code status. At 2:20 PM, Surveyor again requested Resident 5's code status paperwork from Administrator B. Administrator B stated they did not have code status paperwork for Resident 5 because they believed the medical examiner had taken it with them. On 05/08/2025 at approximately 10 AM, Surveyor reviewed Resident 5's observation notes. An observation note dated 04/23/2025 at 10:30 AM, read: "was doing security checks and found resident laying [sic] in bed unresponsive with no pluse [sic] or respirations ... Writer called 911 at 753AM ... Writer began CPR ... Paramedics showed up at 758AM. Paramedics took over CPR	N 354		

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N 354	Continued From page 9 for writer. Care Coordinator brought paperwork for paramedics to look at. Upon paramedic looking at post form paramedic seen [sic] the last form was dated 2022. Paramedic stated, 'This is expired,' and paramedic called Gundersen hospital to verify... doctor had paramedic call time of death." On 05/15/2025 at approximately 10:05 AM, Surveyor interviewed DOO A, Administrator B, and Care Coordinator (CC) J regarding Resident 5's code status and situation. DOO A explained they do not provide CPR at the facility. S/he stated the staff were not trained to provide CPR. DOO A stated they performed CPR because that was what 911 dispatch instructed them to do. DOO A, Administrator B, and CC J all acknowledged that the computer system was the first place staff look for code status and that it was wrong for Resident 5. DOO A stated, "I can't say how it happened or why it was green... falls on the whole team for not updating that." At approximately 10:10 AM, CC J stated that caregivers can find all the information needed for residents in an emergency in the computer. S/he stated they also have an emergency folder. CC J stated that the emergency folder was where they found Resident 5's DNR paperwork. S/he stated it was found after the fact. CC J stated, "It showed green, I don't know how it happened, I can't say, but it was not matching." CC J stated that this taught everyone a "large" lesson. S/he stated they have since rechecked everyone's files.	N 354		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope.	N 386		

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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 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 ensure Resident 1 had a comprehensive individualized service plan (ISP) that identified Resident 1's needs and desired outcomes related to his/her wandering and elopement risk.

Resident 1 was provided a wander guard upon admission. It was subsequently removed during a medical appointment and staff did not ensure it was put back on. Resident 1 eloped from the facility on 12/28/2024.

This is a repeat deficiency. See Statement of Deficiency (SOD) H7LH11, dated 04/07/2022.

Findings include:

On 03/10/2025, the department received a complaint regarding resident elopements.

On 01/02/2025, the department received a self-report from the provider. The self-report

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indicated Resident 1 eloped from the facility on 12/28/2024. The report included a subsection titled, "Action Taken to Ensure Resident's Health, Safety, and Well-Being," and it read, "Facility was aware that resident was a wander risk [sic] and a wander guard was given to resident to wear on [his/her] right ankle at admission. Resident was at the hospital a couple of weeks ago and had to have an MRI done, so the hospital cut [his/her] wander guard bracelet. The Administrator just found out when resident eloped that [his/her] wander guard was cut off. The Resident is also on a 30 minutes [sic] check daily now."

On 05/07/2025 at approximately 10:00 AM, Surveyors interviewed Director of Operations (DOO) A and Administrator B. Administrator B stated Resident 1's wander guard was cut off during a medical appointment and s/he suspected the wander guard was given to Resident 1's family member. Administrator B stated they did not know the wander guard was off. Surveyor requested Resident 1's 30 day comprehensive ISP.

Resident 1 was admitted on 11/01/2024 with multiple diagnoses, including unspecified dementia. Resident 1's "30 Day Assessment," dated 11/30/2024, identified Resident 1 as a wander risk. It did not indicate Resident 1 was provided a wander guard or instruction for staff to ensure Resident 1 was wearing a wander guard. Resident 1's "60 Day Assessment," dated 01/07/2025, identified Resident 1 as a wander risk and elopement risk. It did not indicate Resident 1 had a wander guard or instruction for staff to ensure Resident 1 was wearing a wander guard.

On 05/15/2025, at approximately 10:30 AM,

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N 386	Continued From page 12 Surveyors interviewed DOO A and Administrator B via Teams meeting. Surveyor asked if Resident 1's "30 Day Assessment" provided by Administrator B was considered Resident 1's comprehensive ISP. DOO A stated the ISP was the assessment and the ISP was strictly for office staff. DOO A stated not all staff had access to the ISP because that would be "chaotic." DOO A stated that whatever was included in the 30 day and 60 day assessments, would be imported into a care plan that staff could see. Surveyor expressed concerns related to staff awareness of the wander guard and it not being captured on the ISP. Surveyor noted some confusion between parties regarding the titles of each piece of documentation. Surveyor requested they send whatever they considered the comprehensive ISP that may include information regarding Resident 1's need for a wander guard. At 11:37 AM, Surveyor received an email from Administrator B. The email included a document titled, "Service Plan Task." It did not include the required components of an ISP. It included a section titled, "Check Wander Guard Instructions: 1st and 2nd shift: Please check to see if resident wander guard is in place on resident's right leg AND functioning properly. NOC (overnight) shift: Please check to see if resident wander guard is in place on resident's right leg. Please notify administrator if the wander guard is missing or not functioning properly. Status: Resident to be safe and not elope by having her wander guard on with checks." The section included a start date of 03/13/2025 and did not have an end date. Cross Reference N0426 DHS 83.38(1)(b) Supervision	N 386		

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N 426	Continued From page 13	N 426		
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 record review and interview, the provider did not provide supervision adequate to meet the needs of all residents. Staff did not ensure Resident 1 was wearing his/her wander guard, which resulted in Resident 1 eloping from the provider on 12/28/2024. Staff did not respond appropriately to a door alarm, which resulted in Resident 1 eloping from the facility on 05/04/2025. This is a repeat deficiency. See Statement of Deficiency (SOD) J0PF11, dated 10/06/2023. Findings include: On 01/02/2025, the department received a self-report from the provider. The self-report indicated Resident 1 eloped from the provider on 12/28/2024. The report stated, in part, "Resident eloped through the exit entrance of the new side of the building. Resident walked to the [Auto	N 426		

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	0018289	A. BUILDING: _____ B. WING _____	R-C 05/07/2025

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Shop] across the street from the facility. A staff from the automobile [sic] came and notified us to see if we had a missing resident ..." Under a subsection titled, "Action Taken to Ensure Resident's Health, Safety, and Well-Being," it read, "Facility was aware that resident was a wander risk [sic] and a wander guard was given to resident to wear on [his/her] right ankle at admission. Resident was at the hospital a couple of weeks ago and had to have an MRI done, so the hospital cut [his/her] wander guard bracelet. The Administrator just found out when resident eloped that [his/her] wander guard was cut off. The Resident is also on a 30 minutes [sic] check daily now."

On 03/10/2025, the department received a complaint regarding staff supervision and resident elopements.

On 05/06/2025, the department received a self-report from the provider. The self-report indicated Resident 1 eloped from the facility on 05/04/2025. The report stated, in part, "Writer was told by a resident [Resident 3] that an alarm was going off on the new side. Writer went to check it out and found that the back door leading to the back parking lot was going off (wander pendant alert in the system shows a time of 3:24pm) ...Writer spoke to POA (Power of Attorney) at 4:17pm and verified that resident's current location was unknown ...Holmen Police returned the resident to the facility at 4:44PM safe."

On 05/07/2025, at approximately 10:00 AM, Surveyors interviewed Director of Operations (DOO) A and Administrator B. When asked about the provider's call light system, Administrator B stated they constantly had issues with the

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N 426	Continued From page 15	N 426		

system. Administrator B stated the phones used by staff would intermittently work and not work. DOO A stated staff had the ability to silence the alerts and they could not stop staff from doing that. DOO A stated s/he was uncertain if staff were silencing the phones, but it was possible. Administrator B stated they had a history of connection problems. Administrator B stated that when a facility exit door alarm activated, it was generated on the call light logs and staff should be alerted via phone. DOO A stated they needed the door alarms to be louder, but they were currently at the loudest volume. Administrator B stated the door alarms on the new side of the building would only ring on the new side. Administrator B stated the alarm would not sound throughout the building and staff needed to respond urgently when the alarm was activated. Administrator B stated the provider had another elopement last weekend and it involved Resident 1. Resident 1 was believed to have eloped through the same door as his/her previous elopement. Administrator B stated Resident 1 was located at the auto shop across the street. When asked if the door alarmed during those elopements, Administrator B stated the door did alarm and staff did not hear it. Administrator B stated it was possible that staff were in the middle of providing cares to other residents and they did not follow up until after they completed their tasks.

Resident 1 was admitted on 11/01/2024 with multiple diagnoses, including unspecified dementia. Resident 1's "30 Day Assessment," dated 11/30/2024, identified Resident 1 as a wander risk. Under the section titled, "Wandering," it read, in part, "Resident requires supervision and redirection from staff to help prevent wandering episodes. Not exit -seeking/no

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previous occurrences of elopement ...Staff need to regularly monitor and redirect resident if [s/he] is by the entrance." Resident 1's "60 Day Assessment," dated 01/07/2025, identified Resident 1 as a wander risk and elopement risk. Under the section titled, "Elopement Risk," it read, in part, "Requires supervision and redirection to avoid and prevent elopement. Provide checks throughout the day/night and document whereabouts. If elopement occurs, following proper elopement procedures." Under the "Resident's Needs/Preferences" subsection, it read, in part, "Exit seeking and requires checks throughout the day/night." Under the "Service Provider Responsibilities" subsection, it read, "Staff."

On 05/15/2025, at approximately 10:45 AM, Surveyors interviewed DOO A, Administrator B, and Care Coordinator (CC) J via Teams meeting. Surveyor shared concerns related to resident elopements, the provider's call light system, and current door alarms being heard by staff. DOO A stated s/he understood the door alarms might not be loud enough and they bought an external alarm that was going to be a lot louder. DOO A stated it would help the team hear the alarms. DOO A stated they posted a visual reminder throughout the building that instructed staff to stop what they were doing and respond immediately if the door alarm sounded. DOO A stated the team was aware that 1 staff member always had to be on the other side of the building. CC J stated staff were tasked to check wander guards daily to ensure they were working. DOO A stated supervisors would test the staff phones daily before distributing them to staff. DOO A stated that way, if the phone stopped working later, it may be because a bad employee silenced it or changed the phone settings. DOO A stated

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N 426	Continued From page 17 that was an ongoing issue. DOO A stated they had a staff meeting yesterday and addressed many of the concerns being discussed. Cross Reference N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan	N 426		
N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on interview, and record review, the provider did not provide or arrange for services to meet Resident 4's behavior management needs. Resident 4 displayed aggressive behaviors that were harmful to him/herself, residents, and staff over 10 times in the last 3 months. Findings include: On 05/07/2025, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 01/31/2025. Resident 4's incident reports included the following incidents: - 02/19/2025, Resident 4 was exit-seeking and getting aggressive. Non-emergency was called.	N 433		

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N 433	Continued From page 18 - 03/01/2025, Resident 4 was going in and out of other resident rooms. Resident 4 was getting violent with staff. Resident 4 was taking items out of the kitchen and off staff's medication carts. When staff intervened, Resident 4 hit staff with closed fist. - 03/01/2025, Staff was trying to redirect Resident 4 when s/he became violent and started "punching staff in the face." - 03/07/2025, Resident 4 was up most of the night sitting in the dining room waiting for someone to come pick him/her up. Resident 4 then started moving closer to the front lobby door and trying to open it. When Resident 4 was unable to get out [sic] s/he started kicking the door and became "violent." Non-emergency was called. - 03/11/2025, Resident 4 starting [sic] hitting caregiver when s/he tried giving Resident 4 his/her medications. - 03/14/2025, Resident 4 suddenly became agitated. Resident 4 started "yelling at him/her and grabbed on to his/her arm". Resident 4 continued to walk around the dining room and pick up other resident's things. Resident 4 tried to leave by exiting the back door. - 03/18/2025, Resident 4 was chasing caregiver around dining room table and threatening other residents. Non-emergency was called. - 03/23/2025, Resident 4 was blocking door with chair and then trying to climb over it. Resident 4 got angry and slapped staff in the face. Resident 4 was attempting to lift his/her bedroom door off the hinges. Resident 4 locked staff in his/her room and would not let them leave.	N 433		

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N 433	Continued From page 19 - 04/09/2025, Resident 4 went after staff with hot coffee and was going to pour it on staff's head. - 04/09/2025, Resident 4 kicked another resident in the butt. Resident 4 was also running at staff members. - 05/03/2025, Resident 4's behavior "escalated." Resident 4 had picked up a chair and was going after other residents. When staff intervened, Resident 4 "began to punch writer with his/her right arm [sic] landing 5 blows to writer's left upper and lower side of writers body." 911 was called. Resident 4 was chasing other residents and trying to exit the building. Resident 4 got outside and started running. Resident was found by police officers. On 05/07/2025 at 10:30 AM, Surveyors interviewed Director of Operations (DOO) A and Administrator B. Administrator B stated that Resident 4 was an elopement risk and they had implemented a wander guard. Administrator B also stated Resident 4 had frequent behavioral issues. S/he stated that during Resident 4's pre-admission assessment, s/he was independent and had no behaviors. Administrator B stated that once Resident 4 moved in, s/he started having increased behaviors and hallucinations. Administrator B stated that Resident 4's provider did not want to start any interventions until there was a pattern. On 05/07/2025 at 11 AM, Surveyors interviewed Registered Nurse (RN) I about Resident 4's behaviors. RN I stated that Resident 4 had frequent aggressive behaviors. RN I stated Resident 4's provider had made some medication changes, which resulted in a few good weeks.	N 433		

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However, Resident 4's behaviors started to increase recently. RN I stated that Resident 4 was scary due to his/her size and strength. RN I stated the only non-pharmacological interventions the provider had implemented were to try and keep everyone safe and to redirect Resident 4.

On 05/13/2025 at approximately 11:50 AM, Surveyor received the most updated copy of Resident 4's Individual Service Plan (ISP).

Resident 4's (ISP), updated 02/15/2025, did not indicate that s/he had any destructive or abusive behaviors. Under the mental health section of Resident 4's ISP, it also did not indicate that Resident 4 displayed any aggressive/combative behaviors. Resident 4's ISP did show that s/he was a wandering risk. Under wandering risk, it stated, "Requires supervision and redirection from staff to help prevent wandering episodes. Not exit-seeking/no previous occurrences of elopement."

On 05/15/2025 at approximately 10:00 AM, Surveyor interviewed Director of Operations (DOO) A, Administrator B, and Care Coordinator (CC) J regarding Resident 4's behavior patterns. DOO A stated they have been working with Resident 4's managed care organization (MCO). S/he stated they were still waiting for the MCO to provide some "interventions training" to staff. DOO A stated staff were trained on redirection of resident. S/he also stated they instruct staff to avoid Resident 4's triggers. CC J stated that the behaviors were all new and they have only been happening for a short period of time. DOO A stated they show the team what to do, and if the ISP was not updated that falls back on the team.

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N 481	Continued From page 21	N 481		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not provide an environment that was safe, clean, comfortable, and homelike. Findings include: This is a repeat deficiency. See Statement of Deficiency (SOD) J0PF11, dated 10/06/2023. The department received a complaint related to facility cleanliness. On 05/07/2025 at approximately 11:50 AM, Surveyor observed Resident 2's room. Upon entering Resident 2's room, Surveyor noticed a strong smell like urine. Surveyor also noticed that the floor appeared to be sticky. A pile of dirty clothes and bedding appeared to be lying on the floor near the resident's door. Surveyor also observed a leftover plate with half eaten breakfast food that was still sitting on Resident 2's bedside table. Surveyor then observed Resident 6's room. There was a pile of bed sheets and blankets on the floor in the doorway. The resident's bed was unmade. Surveyor interviewed Resident 6 about the bedding lying on the floor. Resident 6 stated	N 481		

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N 481	Continued From page 22 that no one had come back to make it yet. Surveyor also noticed an abundance of empty soda cans all around Resident 6's room as well. Surveyor observed Resident 7's room. Upon entering the room, Surveyor noticed there was multiple pieces of chewed gum on the floor and in the laundry basket near the door. Surveyor also noticed an unmade bed. In addition, there was what appeared to be a soiled brief on the Resident 7's chair. On 05/15/2025 at approximately 10:25 AM, Surveyor interviewed Director of Operations (DOO) A, Administrator B, and Care Coordinator (CC) J, regarding room cleanliness. DOO A stated s/he thought room cleaning was being done. DOO A did state s/he hears a lot of noise from the different caregivers about things not getting done. S/he stated the team was always pointing fingers at each other. DOO A acknowledged the concern and stated that his/her shift lead should be monitoring the rooms and making sure they are being kept clean every shift.	N 481		