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N 000	Initial Comments On 09/05/2024, Surveyor conducted two (2) complaint investigations and reviewed one (1) self report at Pleasant Park Place. As a result of the survey three (3) deficiencies were identified. One complaint was substantiated. One complaint was unsubstantiated. Census: 29	N 000		
N 431	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.	N 431		

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

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This Rule is not met as evidenced by:
Based on record review and interview the provider did not ensure changes in the health of 1 of 2 residents reviewed were monitored and documented in the resident's record. Resident 3's skin concerns were not monitored and changes were not documented in Resident 3's record.

Findings include:

On 09/05/2024, Surveyor conducted a complaint investigation alleging the provider did not meet the needs of residents.

On 09/05/2024 at approximately 10:00 a.m., Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider's facility on 11/22/2013 with diagnoses including diabetes and schizoaffective disorder. Resident 3 had a legal guardian. Resident 3's individual service plan (ISP), dated 07/17/2024, indicated Resident 3 required the provider's staff to administer medications, assist with bathing (although often refused) and monitor for potential skin breakdown. The ISP stated Resident 3 had a history of ulcers/skin conditions, including psoriasis and required staff to offer to apply cream.

Resident 3's record included the following progress notes and incident reports, dated 07/01/2024 to 09/05/2024:

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N 431	Continued From page 2 - 07/02/2024: Skin under resident's breast is so raw and open that a yeast infection is starting. As of right now we have a washcloth under them to soak up whatever possible and tomorrow to put some gauze for protection. - 07/03/2024: Resident skin is reddened and very painful under his/her left (chest fold) from where the (chest fold) sits on skin and almost to nipple area. Has red painful area along abdominal fold on left side. Resident indicated a pain level of "10." *No documented monitoring of Resident 3's skin concerns from 07/04/20204 - 07/06/2024. - 07/07/2024: Resident reports the rash under (chest folds) and abdominal folds are less itchy. *No documented monitoring of Resident 3's skin concerns from 07/08/2024 - 07/20/2024. - 07/21/2024: Resident has been complaining of pain under (chest folds) and abdominal fold. Areas are red and tender to touch. Nystatin powder applied to area. *No documented monitoring of Resident 3's skin concerns from 07/22/2024 - 07/25/2024. - 07/26/2024: Note from 07/24/2024 dermatology appointment - Continue with Triamcinolone .1% cream, apply twice daily for 3-4 days as needed to active patches from neck down. Enbrel injection every week. Continue Nystatin powder - Apply 2 times daily as needed. Ketoconazole cream 2% - Apply 2 times daily as needed to skin fold areas. *No documented monitoring of Resident 3's skin concerns from 07/27/2024 - 07/30/2024. - 07/31/2024: Area under (chest folds) and abdomen seems to be healing well. Not as red or tender. - 08/25/2024: Resident had Nystatin powder put on under (chest folds) and as needed for pain. *No documented monitoring of Resident 3's skin concerns from 08/26/2024 - 09/02/2024.	N 431		

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N 431	Continued From page 3 - 09/03/2024: Resident had a very red area under (his/her) right (chest fold). Nystatin powder applied. Resident 3's medication administration record (MAR), dated 07/01/2024 to 09/05/2024, indicated Resident 3's Ketoconazole 2% Cream (Start Date: 03/04/2024) was never applied/administered and Nystatin Powder (Start Date: 07/03/2024) had been applied 3 times (07/15/2024, 08/12/2024, 08/25/2024). On 09/05/2024 at approximately 2:00 p.m., Surveyor interviewed Executive Director A. Surveyor asked about Resident 3's skin concerns. Executive Director A confirmed Resident 3 had a history of skin breakdown and showed Surveyor a picture that had been sent to the facility's nurse on 09/03/2024. The picture showed large bright red areas under Resident 3's chest folds. Surveyor reviewed concern that Resident 3's record would document skin concerns one day, but not document further monitoring or treatment of the skin concerns. Executive Director A agreed with Surveyor's concern and stated s/he believed caregivers were applying creams and powders, but not remembering to document when they did so. Surveyor asked Executive Director A how staff knew if the skin concerns were getting better or worse if there was no documentation of follow up monitoring. Executive Director A nodded his/her head with no further comment. Surveyor asked if Resident 3's record would include any additional documentation of Resident 3's skin concerns. Executive Director A replied, "No." On 09/05/2024 at approximately 2:15 p.m., Surveyor interviewed Resident 3. Resident 3 stated s/he currently had rashes under his/her	N 431		

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N 431	Continued From page 4 chest folds, and it was painful to him/her.	N 431		
N 432	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure medication administration appropriate to 3 of 3 residents reviewed was provided. Resident 4, Resident 2 and Resident 3 did not have all PRN medications available to them for administration. Findings include: On 09/05/2024, Surveyor conducted a complaint investigation alleging the provider did not always have an adequate supply of resident medications. The following concerns were identified: Example 1 - Resident 4: On 09/05/2024 at approximately 10:00 a.m., Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider's facility on 02/17/2023 with diagnosis of diabetes and	N 432		

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dementia. Resident passed away on 08/29/2024. Resident 4 was on service with hospice. Resident 4's physician orders included Glucose 40% Gel (Start Date: 04/12/2024) for low blood sugars. Resident 4's record included a hospice note, dated 07/03/2024, that stated hospice conducted a visit on 07/02/2024 due to Resident 4 being minimally responsive with fixed gaze, drooling, unable to follow instructions and "dead weight" when facility staff attempted transfer. The note stated a random blood glucose was checked and reading was 63. The note stated Hospice RN instructed facility staff to locate PRN Glucose gel and administer it; however facility staff could not locate Glucose gel in medication cart or medication room. The note stated the Hospice RN administered 2 teaspoons of maple syrup and Resident 4 began to come to within minutes.

On 09/05/2024 at approximately 10:45 a.m., Surveyor interviewed Executive Director A and Caregiver B, who was responsible for ordering resident medications. Surveyor shared concern that Glucose gel was requested but unavailable for Resident 4 when s/he had a low blood sugar. Caregiver B nodded his/her head in acknowledgement of Surveyor's concern. Executive Director A stated the pharmacy had the ability to deliver medications daily, but acknowledged there may be a time gap from the time medication was requested to delivered and some medications could not wait for administration.

Example 2 - Resident 2 and Resident 3:

On 09/05/2024 at approximately 10:30 a.m., Surveyor interviewed Caregiver C. Caregiver C stated the facility did have a history of running out of diabetic supplies and PRN medications, such

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as Loperamide. Caregiver C stated at those times, s/he would need to take from another resident and s/he didn't like doing that. Surveyor then reviewed Resident 2 and Resident 3's medication supply/storage and physician orders with Caregiver C, which indicated the following:

- Resident 2 was admitted to the provider's facility on 11/22/2023. Resident 2 had the following medications prescribed, but unavailable to him/her in storage: Acetaminophen 325 mg (Start Date: 10/03/2023)- Take 2 tables by mouth every 6 hours as needed for pain, Antacid (Start Date: 12/29/2023) - Take 10-30 ml every 4 hours as needed for stomach discomfort/heartburn/gas, Bisacodyl 10 mg (Start Date: 12/29/2023) - Insert 1 suppository rectally every 3 days as needed for constipation, Bismuth 525 mg/30 ml (Start Date: 12/29/2023) - Take 30-60 ml every hour as needed for stomach discomfort/diarrhea, Calcium Carb 500 mg (Start Date: 02/05/2024) - Chew 2 tablets every 4 hours as needed for stomach discomfort/heartburn/gas, Chloraseptic Sore Throat and Spray (Start Date: 12/29/2023) - Take 1 lozenge every 4 hours as needed and 1 spray every 4 hours as needed for sore throat, Diphenhydramine 25 mg (Start Date: 12/29/2023) - Take 1-2 capsules every 4-6 hours as needed for allergic reaction, Docusate Sodium 100 mg (Start Date: 12/29/2023) - Take 1-2 capsules as needed for constipation, Guaifenesin and Guaifenesin DM (Start Date: 12/29/2023) - Take 5 ml every 4 hours as needed for cough and congestion, Ibuprofen 200 mg (Start Date: 12/29/2023) - Take 1-2 tablets every 4 ours as needed for pain/fever, Milk of Magnesia (Start Date: 12/29/2023) - Take 30 ml by mouth up to 2 doses as needed for constipation and Trolamine Salicylate 10% Cream (Start Date: 12/29/2023) - Apply topically as needed for muscle soreness.

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N 432	Continued From page 7 - Resident 3 was admitted to the provider's facility on 11/22/2013. Resident 3 had the following medications prescribed, but unavailable to him/her in storage: Glucagon Hypokit 1 mg (Start Date: 02/26/2024) - Inject 1 ml as needed for low sugar levels, Ketoconazole 2% cream (Start Date: 03/04/2024) - Apply topically under breasts or skin folds as needed for fungal rash, Trolamine Salicylate 10% cream (Start Date: 03/04/2024) - Apply topically as needed for muscle soreness, Loperamide 2 mg (Start Date: 02/01/2024) - Take 1 capsule as needed after each loose stool and Bisacodyl Suppository (Start Date: 03/04/2024) - Insert 1 suppository rectally every 3 days as needed for constipation. On 09/05/2024 at approximately 12:45 p.m., Surveyor reviewed medications s/he was unable to locate for Resident 2 and Resident 3 with Executive Director A and Caregiver B. Caregiver B reviewed the provider's medication supply and confirmed medications were unavailable. Executive Director A replied, "We wouldn't have all of the PRNs. We would ask pharmacy to deliver them if needed." Surveyor asked how quickly medications would be delivered from pharmacy. Executive Director A stated pharmacy was able to deliver daily, but s/he couldn't give a timeframe as to when medications would be delivered if a PRN medication request was made.	N 432		
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	N 433		

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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 record review and interview, the provider did not provide services to manage 1 of 2 residents reviewed that had behaviors which were harmful to him/herself and others. Resident 1 had behaviors of physical aggression towards residents and staff, sexually inappropriate comments, elopements, property destruction, verbal aggression, threats, frequent possession of sharp objects and intermittent law enforcement that were not managed.

Findings include:

On 09/05/2024, Surveyor conducted a self-report review regarding Resident 1 becoming physically aggressive with another resident.

On 09/05/2024 at approximately 9:45 a.m., Surveyor interviewed Caregiver B. Caregiver B stated Resident 1 was "sweet" one day and a "ticking time bomb" the next. Caregiver B stated the provider encouraged entertainment like taking a walk, playing guitar, or watching a movie when Resident 1 was triggered/upset, but that interventions rarely worked.

On 09/05/2024 at approximately 10:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 resided at the provider's facility from 10/27/2023 to 07/15/2024. Resident 1's diagnoses included Wernicke's encephalopathy and alcohol abuse. Resident 1 had a legal guardian. Resident 1's progress notes, incident reports and facility

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self-reports included the following documentation of behaviors:

- 10/27/2023: Resident got out the front door and refused to come inside. Redirection was not working. Staff walked around outside with resident and (s/he) returned inside.
- 10/28/2023: Threatened to break a window if not able to go outside.
- 10/30/2023: Eloped to parking lot.
- 11/20/2023: Found a "shank" in resident's room.
- 11/29/2023: Verbally aggressive toward staff when redirecting (Resident 1) from the facility freezer. Hit a staff member. Three staff were able to calm resident down with coffee.
- 12/14/2023: Resident gave staff a hug, began kissing staff down (his/her) neck and wouldn't let go of staff. Staff attempted to stay away from resident for the remainder of the shift, but resident again grabbed staff at supper and kissed staff's eye.
- 12/20/2023: Resident pushed past staff and sprinted outside.
- 12/31/2023: Resident pushed another resident to the ground after the other resident asked resident not to go in the kitchen. Resident grabbed the face of the caregiver that intervened. Law enforcement was called.
- 01/04/2024: Observed with a knife.
- 01/05/2024: Resident had a knife in (his/her) room.
- 01/18/2024: Resident had a panic attack from fire alarm testing.
- 01/22/2024: Made inappropriate comments to staff about their bodies.
- 01/22/2024: Had a knife.
- 01/23/2024: Made sexual comments to staff.
- 01/25/2024: Made inappropriate comments to staff. Staff noticed something shiny in (his/her) pocket [concerning for a knife], but was unable to

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obtain in.
- 01/30/2024: Altercation with another resident. Punched the resident in the nose and grabbed (his/her) hair. Resident stated on 3 occasions, "If you don't keep [him/her] away from me, I will kill [him/her]. I'm a veteran with PTSD and the government will excuse me." Law enforcement was called, but would not intervene since (Resident 1) is protectively placed by another county. (Family Member) voiced concerns that (Resident 1) may seriously harm someone at the facility. Physician visiting tomorrow. Placing agency seeking alternate placement.
- 01/31/2024: Incessantly paced hallways. Not friendly or engaged as normal.
- 02/01/2024: Attempted to leave.
- 02/03/2024: Attempted to elope. Upon returning to the building, kissed staff member multiple times.
- 02/05/2024: Staff member found resident down the road alone when coming into work.
- 02/06/2024: Resident observed with a kitchen knife. Staff located a butterknife and 2 pairs of scissors in (his/her) belongings.
- 02/06/2024: Resident was found walking down the block. Staff chased (him/her) to get (him/her) back to the building.
- 02/07/2024: Two pairs of kitchen scissors found in (Resident 1's) bag.
- 02/08/2024: Exit seeking.
- 02/10/2024: Upset that staff didn't have ribeye, steak or lobster to serve. Threw (his/her) entire tray across the living room, shattering the plate.
- 02/18/2024: Continuously walked out of building.
- 02/19/2024: Eloped. Staff responded to door alarm and redirected.
- 02/20/2024: Resident clenched fists and raised voice toward a caregiver regarding coffee. Removed a sharp and 3 scissors from (his/her) lunch bag today. Resident continued going into

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the mechanical room trying to unplug wires. Resident was found in the kitchen trying to steal a knife and scissors. When confronted, (s/he) made threats to staff by yelling and waving (his/her) hands in their face.
- 02/21/2024: Resident threatened caregivers, became physical with caregivers, threatened suicide and became combative with police last night. Resident was taken to the hospital but returned to facility.
- 02/22/2024: Resident had a pair of scissors and got very close to staff's face when trying to confiscate the scissors. Resident raised (his/her) fist at staff. Placing agency offered increased rate for resident and continues to look for alternate placement. Placing agency did not believe a psychiatric evaluation is appropriate due to Wernicke's encephalopathy diagnosis.
- 02/27/2024: Scissors and butter knife removed from (Resident 1's) room today.
- 03/01/2024: Resident used a butter knife and scissors to cut boxes. A butter knife, scissors and larger knife were later confiscated.
- 03/02/2024: Resident observed cutting cardboard with a knife.
- 03/03/2024: Resident found in the kitchen looking through the silverware drawer. Resident responded to staff redirection with verbal aggression. Later in the day, walked out front door.
- 03/04/2024: Had a pair of scissors.
- 03/08/2024: Threw another resident's chair alarm on the ground, breaking the alarm in half. Resident had a butter knife and 2 pairs of scissors.
- 03/09/2024: Confiscated a knife from resident today.
- 03/11/2024: Resident started having behaviors due to chair alarms of other residents going off. Caregivers noticed Resident 1 has a butterknife.

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(S/he) made passive statement about wanting to harm staff. Staff failed several attempts to de-escalate the behaviors and disengaged to avoid any further issues.
- 03/13/2024: Resident observed with a pair of scissors.
- 03/14/2024: A pair of scissors and a knife were found in (Resident 1's) room.
- 03/23/2024: Wandered and got in staff's face yelling at staff. Resident stated, "I'm coming for you" and came back from (his/her) room with a pair of scissors. (S/he) had been trying to get into other residents' rooms, the kitchen and beauty salon, presumably looking for weapons.
- 03/24/2024: Attempted to push past staff to enter the kitchen. Found with a pair of scissors.
- 03/25/2024: Confiscated a paint scraper from (Resident 1's) room.
- 03/27/2024: Had what looks like a box cutter or knife of some kind.
- 03/29/2024: Resident wandered in/out of kitchen, got into stuff, got in staff's face and attempted to put (his/her) hands on staff.
- 04/05/2024: Cut cardboard with a butter knife. Staff were unable to confiscate the knife. Walked out the front door at one point today and was redirected by staff. Confiscated a pair of scissors.
- 04/09/2024: Verbally aggressive toward staff when asked to leave the kitchen.
- 04/16/2024: Had scissors and a butter knife.
- 04/19/2024: Confiscated a butter knife that (s/he) was sharpening with a nail file. The butter knife was sharp. Kept going into kitchen, taking things and unlocking the doors. Had a pair of scissors.
- 04/23/2024: Stole food from freezer, such as shrimp, fish and hot pockets. Used microwave in the back office to warm the food.
- 04/24/2024: Awake, walked around and dug in staff's stuff. Wanted to fight with staff. Had a

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PLEASANT PARK PLACE	1450 N PLEASANT ST RIPON, WI 54971

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butter knife.
- 04/25/2024: Observed cutting boxes with a big sharp knife. Resident got hostile when caregiver asked for knife.
- 04/26/2024: Stole food from the freezer and cooked it in the back microwave.
- 04/30/2024: Resident microwaved a piece of cardboard for the max time in restricted area, causing a small fire. Staff put out the fire and locked up the microwave.
- 05/02/2024: Observed sharpening a butter knife with a nail file.
- 05/15/2024: Witnessed resident sharpening a butter knife with the stone of the fireplace. When staff intervened, resident became verbally aggressive. Resident walked out the front door and attempted to get inside a staff member's car. Resident walked down the road and staff walked with resident as resident was talking about stomping on people's necks.
- 05/21/2024: Resident smacked another resident. Resident that witnessed the incident stated (Resident 1) smacked the left side of the other resident's face and punched the resident after (s/he) began to cry. Law enforcement was called. No intervention.
- 05/29/2024: Resident eloped. Staff had to follow (him/her) in their car. Resident refused to get into car, so staff had to walk back to facility with (him/her).
- 06/04/2024: Found twice in the kitchen. Verbal aggression towards caregiver regarding a remote. Found with 3 pairs of scissors and a nail file that was being used to sharpen the scissors.
- 06/09/2024: Yelled at another resident because the other resident was sitting in "[his/her]" chair.
- 06/17/2024: Resident observed outside. Staff attempted to redirect resident, but resident walked all the way down the street. When cars were coming, (Resident 1) kept looking down and

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would not listen to caregiver's request to move to the sidewalk. Maintenance personnel picked resident up in (his/her) car. Upon return to the facility, (Resident 1) became upset and left the property again. Law enforcement was called. Maintenance personnel brought (Resident 1) back to the facility again.
- 06/18/2024: Resident exited the front door and was followed by caregiver. When a cab pulled up, resident tried getting in the cab. While caregiver attempted to stop (Resident 1) from entering the cab, (Resident 1) began punching caregiver in the arm and neck area. Law enforcement was called.
- 06/19/2024: Observed walking outside without another caregiver. Able to redirect.
- 06/24/2024: Verbally aggressive towards staff. Going in/out of other resident's rooms.
- 07/02/2024: Verbal altercation with another resident.
- 07/08/2024: Front door alarmed. Found (Resident 1) in the road trying to pawn a ring. Resident was found with (his/her) hand over another resident's mouth and punching the other resident with (his/her) other hand. Law enforcement was called.
- 07/09/2024: Found sharpening an item on the fireplace. Had a pair of scissors.
- 07/11/2024: Resident was outside trying to get into staff cars.

Resident 1's individual service plan (ISP) that had been reviewed by all involved parties, dated 12/11/2023, included the following regarding behaviors and interventions:

- Attitude: Resident expresses delusions throughout each day, team has gently attempted to remind resident of reality which causes increased exit seeking behaviors as well as

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mistrust. Team will utilize therapeutic fibbing in regard to resident's daily delusions.
- Destructive/Abusive: Resident displays no destructive/abusive behaviors.
- Aggressive/Combative: Resident displays no aggressive/combative behaviors.
- Behavior/Conference Call: Resident is on a behavior/clinical call bi-weekly with a behavior management consultant along with the Director, Director of Operations, and nurse. Physician will be notified to request medication adjustments. Team members will be trained on potential interventions to alleviate resident behavior.

Resident 1's ISP that was effective upon discharge had the following revisions:

- One Hour Checks: Check on residents every hour and 3 times during the night.
- Wandering: Resident needs full supervision and redirection/interventions from the team to avoid and prevent constant exit seeking. The Team will provide 1 on 1 when the exiting is constant with redirection that could not be working. When resident is exit seeking, team will redirect with conversations about the military or music or just ask him/her questions about his/her life.
- Room Check: Team will check resident's room and "lunch box" for any items of concern including scissors, knives, broken glass, kitchen utensils, etc. and remove them from the room.
- Aggressive/Combative: Resident is lightly monitored and cued to avoid aggressive/combative episodes. Resident has a history of being physically aggressive with team members and other residents - Team will monitor and redirect any of these aggressive behaviors immediately. Resident has the following behaviors - 1. Elopement Risk - S/he attempts to leave stating s/he does not belong here. S/he

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wants to go home or at times attempts to leave to get chewing tobacco - S/he is easily redirected when staff talk with him/her about his/her life. Staff will ensure s/he always has tobacco on hand. 2. Sexually inappropriate toward female staff - S/he has attempted to grope staff and kissed them. S/he is informed that its inappropriate but s/he says s/he can't help it - This has not been a regular occurrence. 3. Combative - Resident has been combative with another male resident in which police were involved - Team will intervene as needed to keep separation and all residents safe. 4. Weapon Seeking - Resident attempts to go into the kitchen and take knives. Team occasionally finds them in residents room and removes them. S/he has not attempted to hurt anyone with a knife yet, s/he typically hides them when s/he does get them. All knives get locked up in a locked cabinet in the kitchen. 5. Yells at team - Resident at times yells at team saying s/he can't eat the food here. Team will offer alternatives. 6. Delusion thoughts - Resident has many stories that are not real but are true to him/her. S/he thinks s/he has 4 PHds, is married to famous people, was asked by the president to write a book, that s/he is the one that found Osama Binladin, etc.. Many, many stories - Team do not correct. They shall listen to his/her stories. 7. PTSD - When fire alarms go off resident runs around screaming "Get out, Take Cover" and s/he attempts to get outside to take cover. Once alarms stop so does his/her PTSD episode. Team will take resident out for a walk. *Revision dates were not documented.

Resident 1's record included documentation indicating medication changes were made on 10/31/2023, 12/11/2023, 01/16/2024 and 04/22/2024; however, Resident 1 had a history of refusing medications. Resident 1's record did not

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indicate new interventions to prevent behaviors after behaviors occurred but did indicate a 30-day notice terminating placement was issued on 02/01/2024 and frequent calls were made to Resident 1's placing agency to work on alternate placement.

On 09/05/2024 at approximately 2:00 p.m., Surveyor interviewed Executive Director A. Surveyor reviewed Resident 1's behaviors, including 4 physical altercations with other residents, physical altercation with staff, sexually inappropriate behaviors, elopements, property destruction, verbal aggression, threats, frequent possession of sharp objects and intermittent law enforcement presence due to behaviors. Executive Director A stated Resident 1's behaviors were difficult to manage and it was important for staff to pay attention to triggers, such as others going near Resident 1's belongings, running out of tobacco, loud noises or being told no. Surveyor asked what the provider did to manage Resident 1's behaviors, particularly physical aggression towards other residents, and ensure Resident 1 and all other residents and staff remained safe in the facility. Executive Director A was unable to identify other interventions not reviewed in Resident 1's record. Surveyor shared concern that Caregiver B described Resident 1 as a "ticking time bomb" and asked how 1-hour checks were beneficial if Resident 1's behavior was unpredictable. Executive Director A nodded his/her head and voiced agreement that Resident 1 may have required more interventions, such as increased supervision. Surveyor acknowledged the facility had issued a 30-day notice and was working with Resident 1's placing agency on alternate placement for months, but that interventions to manage Resident 1's behaviors in the interim

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N 433	Continued From page 18 were limited and continued to put Resident 1 and others at risk of harm. Executive Director A made no further comments related to Resident 1's behaviors.	N 433		