STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017702	A. BUILDING: _____ B. WING _____	C 07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF MADISON OAKWOOD	5555 BURKE RD MADISON, WI 53718

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 07/11/2023, Surveyor completed 2 complaint investigations at Cottages of Madison Oakwood, a CBRF in Madison. Twelve deficiencies were identified. Eight deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) EC0P11, dated 03/23/2021, SOD EC0P12, dated 06/15/2021, SOD EC0P13, dated 10/05/2021, SOD GT2Y11, dated 10/13/2021, SOD 32ME11, dated 01/06/2022, SOD EC0P14, dated 03/29/2022, SOD EC0P15, dated 07/13/2022 and SOD EC0P16, dated 10/07/2022. Two of 2 complaints were substantiated. Census: 16	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure law enforcement responding to the facility for the safety of residents was reported to the department. The facility did not report an incident in which law	N 164		

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

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N 164	Continued From page 1	N 164		

enforcement responded to the facility because Resident 1 was verbally abusive to staff and residents.

This is a repeat deficiency. See Statement of Deficiency (SOD) 32ME11, dated 01/06/2022.

Findings include:

On 07/11/2023, Surveyor completed a complaint investigation alleging a resident had left the facility and returned intoxicated.

On 07/05/2023 at approximately 11:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 04/21/2023 with diagnoses of Wernicke's encephalopathy, history of alcohol abuse and history of cocaine abuse. Resident 1's progress notes included a note, dated 06/02/2023, which stated, "Resident was mad [s/he] could not drink and got verbally abusive towards staff and residents. Staff called police and they picked up resident."

On 07/05/2023 at approximately 12:30 p.m., Surveyor reviewed progress note, dated 06/02/2023, with Sales and Marketing E, Director A and Director B. Surveyor asked if a self-report was completed due to law enforcement being called to the facility for resident safety. Director B replied, "No. I had just started." Director A checked facility records and was unable to locate a self-report. Sales and Marketing E stated lack of self-reports had been identified as a concern in an affiliated facility and the provider had a correction plan to address the issue.

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N 196	Continued From page 2	N 196		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. This is a repeat deficiency. See Statement of Deficiency (SOD) GT2Y11, dated 10/13/2021 and EC0P16, dated 10/07/2022. Findings include: On 07/11/2023, Surveyor completed 2 complaint investigations at the provider's facility. As a result of the investigations 12 deficiencies were identified, 8 of which were repeat deficiencies. Deficiencies included the following: - Medication Storage - Locked Cabinet: The provider did not ensure medications were stored secured with the key only available to the provider's personnel. *This is a repeat deficiency. - Toxic Substances: The provider did not ensure all toxic chemicals were secured and not accessible to residents. Both the laundry room, which stored detergent, and the cleaning/linen closet, which stored cleaning agents, were accessible. *This is a repeat deficiency. - Separate Laundry Storage Areas Or Containers: The provider did not ensure soiled laundry and clean laundry were handled in separate storage areas.	N 196		

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N 196	Continued From page 3 - Clean, Homelike Environment: Soiled laundry was observed on the floor in resident rooms, the facility did not have enough utensils to provide residents for meals, garbage was observed on the floor in the entry and food was observed on the floor in the kitchen. *This is a repeat deficiency. - Leisure Time Activities: The provider did not ensure daily programming was provided for residents. *This is a repeat deficiency. - Resident Records: The provider did not have record of a resident exhibiting shortness of beath and subsequent emergency room visit. - Proof-of-use Record: The provider did not ensure that schedule II medications were audited daily. *This is a repeat deficiency. - Menus: The provider did not ensure a written menu was provided to residents and followed. - Reporting When Law Enforcement Is Called: The provider did not report when law enforcement responded to the facility on 06/02/2023 due to resident behavior. *This is a repeat deficiency. - Assessments: The provider did not ensure assessments were completed when residents exhibited new behaviors. - Individual Service Plan (ISP) Updates: The provider did not ensure ISPs were updated when residents had change in needs or behaviors. *This is a repeat deficiency. On 07/05/2023 at approximately 10:05 a.m., Surveyor reviewed concerns related to toxic chemicals, medication storage, leisure time activities, proof-of-use and menus with Sales and Marketing E. Sales and Marketing E stated the Surveyor set the facility up for failure by conducting complaint investigations the day after a holiday. On 07/05/2023 at approximately 12:30 p.m.,	N 196		

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N 196	Continued From page 4 Surveyor reviewed resident care and resident record concerns with Sales and Marketing E, Director A and Director B. All individuals made note of Surveyor's concerns. Sales and Marketing E stated they already had plans in place to correct most issues identified due to addressing the concerns in an affiliated facility. Cross Reference: N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0409 DHS 83.37(1)(j) Proof-of-use Record N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet N0427 DHS 83.38(1)(c) Leisure Time Activities N0450 DHS 83.41(2)(c) Nutrition: Menus N0454 DHS 83.42(1)(j) Resident Records N0481 DHS 83.43(1) Environment Safe, Clean And Comfortable N0487 DHS 83.44(1)(b) Separate Laundry Storage Areas Or Containers N0499 DHS 83.45(3) Toxic Substances	N 196		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct	N 381		

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N 381	Continued From page 5 the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure assessments were completed when Resident 7 and Resident 4 were observed having a sexual interaction. Findings include: On 07/11/2023, Surveyor completed a complaint investigation alleging that a resident was sexually inappropriate. On 07/05/2023 at approximately 11:00 a.m., Surveyor reviewed Resident 7's records. Resident 7 was admitted to the provider's facility on 08/10/2020 with diagnoses including schizoaffective disorder and bipolar disorder. Resident 7's record included a progress note, dated 06/04/2023, that stated Resident 7 was found in another resident's room with his/her pants down, touching with him/herself. The other resident was naked and touching him/herself. Caregiver intervened and Resident 7 became upset with the caregiver. Resident 7 yelled and became combative with the caregiver. The other resident, identified as Resident 4, did not have documentation of the incident in his/her record. On 07/05/2023 at approximately 11:15 a.m., Surveyor interviewed Sales and Marketing E regarding Resident 7 and Resident 4's interaction. Surveyor asked Sales and Marketing E what follow up was completed. Sales and Marketing E stated the previous director got statements from staff, but Sales and Marketing E	N 381		

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N 381	Continued From page 6 was unable to locate the statements. Surveyor asked if an assessment or individual service plan (ISP) update was completed. Sales and Marketing E replied, "No. I'm frustrated." Cross Reference: N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 381		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not 4 of 4 individual service plans (ISP) were updated when there was a change in the resident's needs, abilities or physical condition. Resident 1's ISP was not updated to include his/her history of leaving the facility and returning with alcohol and/or intoxicated. Resident 6's ISP was not updated to include	N 389		

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his/her need for assistance with toileting every 2 hours.

Resident 7's ISP was not updated to include his/her interactions with another resident.

Resident 4's ISP was not updated to include his/her interactions with another resident.

This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P15, dated 07/13/2022.

Findings include:

On 07/11/2023, Surveyor completed 2 complaint investigations related to resident care at the facility.

On 07/05/2023 at approximately 11:00 a.m., Surveyor reviewed resident records and identified the following concerns:

Resident 1:

Resident 1 was admitted to the provider's facility on 04/21/2023 with diagnosis of Wernicke's encephalopathy, history of alcohol abuse and history of cocaine abuse. Resident 1's progress notes included the following:

- 05/24/2023: Resident 1 was out in front of the building and asked to come inside or at least to the back of the building where s/he can be outside. Resident 1 became verbally upset, screamed obscenities and refused to come inside for an hour.
- 05/31/2023: Resident 1 had been drinking.
- 06/02/2023: Resident 1 was mad that s/he couldn't drink and got verbally abusive towards staff and residents. Police was called and picked

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N 389	Continued From page 8 Resident 1 up. Resident 1's ISP, not dated, stated "We can't do much to prevent [Resident 1] from destroying [him/herself] with [his/her] poor choices and servere mood swings, but maybe we can try to reduce the harm. At the very least, [his/her] care team wants us to help reduce the harm/stress to your staff and residents. Staff will follow the action plan for some guidance/resources. Action Plan: If [Resident 1] isn't an immediate threat of physical harm, you can also call the 24/7 Journey Mental Health Crisis ... If [Resident 1] is starting to get aggressive toward staff or other residents, yelling/swearing, getting in other's personal space, call the police if you are fearful for staff safety or resident safety. I'd say if [s/he] leaves the facility just make note of the time [s/he] left and if [s/he] doesn't return before shift change/med pass/sunset then I think it is reasonable to call 911 for a missing person. You can also call the Madison PD Mental Health Unit ...". On 07/05/2023 at approximately 11:20 a.m., Surveyor interviewed Caregiver D regarding Resident 1's behaviors. Caregiver D stated Resident 1 left the facility on his/her own to go to the park or gas station. Caregiver D stated if Resident 1 got alcohol, s/he would notify management and if Resident 1 was not back to the facility by 9:00 p.m. or returned intoxicated, s/he believed staff were to call 911. On 07/05/2023 at approximately 12:30 p.m., Surveyor discussed Resident 1 leaving the facility and his/her history of intoxication with Sales and Marketing E, Director A and Director B. Director A stated Resident 1 was able to leave the facility independently, but staff were to check Resident	N 389		

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1's belongings for alcohol when Resident 1 returned to the facility. Director A added that if Resident 1 is intoxicated, s/he is supposed to go to his/her room and if Resident 1 became violent, staff were to call 911. Surveyor asked if Resident 1's ISP was updated to reflect the current plan. Director A reviewed Resident 1's ISP and replied, "No."

Example 2 - Resident 6:

Resident 6 was admitted to the provider's facility on 03/15/2019 with diagnosis of dementia. Resident 6's ISP, not dated, stated, "[Resident 6] requires 1 assist with bathing, encourage independence as able. Monitor skin for breakdown, rashes, open areas and report change to facility nurse ... Independent with bathing/showing [sic]. We need to set all [his/her] stuff up in bathroom and check to make sure [s/he] is cleaned up. May need help with back and [gender] parts ... "Independent with toileting. Please watch [him/her] so [s/he] changes [his/her] depends and not have more than one on at a time ... [Resident 6] is independent with toileting and related hygiene. [Resident 6] is continent of bowel and bladder."

On 07/05/2023 at approximately 12:30 p.m., Surveyor asked Sales and Marketing E, Director A and Director B what level of assistance Resident 6 required for bathing and toileting. Director A stated Resident 6 required 1 assist for toileting every 2 hours and 1 assist for bathing. Director A stated the increased assistance had been discussed with Resident 6's family. Director B stated s/he had required assistance of 1 since approximately January 2023. Surveyor reviewed Resident 6's ISP and shared concern that the ISP contradicts itself and does not include need for

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every 2-hour toileting assistance. Director A nodded his/her head in understanding that the ISP needed to be updated.

Example 3 - Resident 7:

Resident 7 was admitted to the provider's facility on 08/10/2020 with diagnoses including schizoaffective disorder and bipolar disorder. Resident 7's record included a progress note, dated 06/04/2023, that stated Resident 7 was found in another resident's room with his/her pants down, touching with him/herself. The other resident was naked and touching him/herself.

On 07/05/2023 at approximately 11:15 a.m., Surveyor interviewed Sales and Marketing E regarding Resident 7's 06/04/2023 interaction with another resident and asked what follow up was completed following the interaction. Sales and Marketing E stated the previous director obtained statements from staff, but Sales and Marketing E was unable to locate the statements. Surveyor asked if an assessment or ISP update was completed. Sales and Marketing E replied, "No. I'm frustrated."

On 07/05/2023 at approximately 12:30 p.m., Surveyor reviewed concern with Sales and Marketing E, Director A and Director B that Resident 7's ISP was not updated to reflect his/her interactions with another resident.

Example 4 - Resident 4

Resident 4 was admitted to the provider's facility on 07/03/1954 with diagnoses including schizoaffective disorder. The chart review of another resident indicated Resident 4 was found pleasuring him/herself with another resident in

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N 389	Continued From page 11 his/her room. Neither Resident 4's progress notes, nor ISP referenced a history of sexual behaviors or a relationship with another resident. On 07/05/2023 at approximately 11:15 a.m., Surveyor interviewed Sales and Marketing E regarding Resident 4's interaction with another resident and asked what follow up was completed following the interaction. Sales and Marketing E stated the previous director obtained statements from staff, but Sales and Marketing E was unable to locate the statements. Surveyor asked if an assessment or ISP update was completed. Sales and Marketing E replied, "No. I'm frustrated." On 07/05/2023 at approximately 12:30 p.m., Surveyor reviewed concern with Sales and Marketing E, Director A and Director B that Resident 4's ISP was not updated to reflect his/her interactions with another resident. Cross Reference: N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments	N 389		
N 409	83.37(1)(j) Proof-of-use record. 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 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. This Rule is not met as evidenced by:	N 409		

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N 409	Continued From page 12 Based on record review and interview, the provider did not ensure schedule II drugs were audited on a daily basis for 1 of 1 residents reviewed. Resident 3's Morphine Sulfate 15 mg was not audited daily. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P14, dated 03/29/2022. Findings include: On 07/11/2023, Surveyor completed a complaint investigation alleging that narcotic medications were not counted. On 07/05/2023 at approximately 8:55 a.m., Surveyor reviewed the facility's medication storage with Director B. The facility had 1 resident that received a schedule II medication. Resident 3 received Morphine Sulfate 15 mg as needed. Surveyor reviewed the facility's medication count history, dated 06/05/2023 to 07/05/2023, which indicated Resident 3's Morphine Sulfate was audited on 06/09/2023, 06/15/2023 and 06/28/2023. Resident 3's Morphine Sulfate was not audited for 27 of 30 days. Surveyor reviewed concern that a daily audit did not occur for Resident 3's Morphine Sulfate with Director B. Director B stated staff should be auditing schedule II drugs every shift and the facility's nurse, who started the week prior, should have audited the counts.	N 409		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF.	N 419		

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N 419	Continued From page 13 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all medications administered by the facility were kept in cabinets that were locked with the key only available to personnel identified by the CBRF. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P12, dated 06/15/2021 and EC0P14, dated 03/29/2022. Findings include: On 07/05/2023 at approximately 8:30 a.m., Surveyor toured the provider's facility. Surveyor observed the facility's medication room was unlocked and accessible. Surveyor observed a bin of medications in the medication room. On 07/05/2023 at approximately 8:55 a.m., Surveyor toured the facility's medication room with Director B. Director B confirmed the medication room, which had a key pad entry, was unlocked and accessible because the lock was not engaged. Director B stated the bin of medications in the room contained medications from June 2023 that were ready to be destroyed. The bin contained medications including Mirtazapine, Clozapine, Donepezil, Buspirone, Metformin, Memantine, Atorvastatin and Melatonin. Surveyor also observed 2 Lantus insulin pens that were accessible in a refrigerator located in the unlocked medication room. The provider did not ensure medications were kept locked.	N 419		
N 427	83.38(1)(c) Leisure time activities.	N 427		

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N 427	Continued From page 14 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: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a daily activity program was provided to residents and that an activity schedule was posted and available to residents. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P11, dated 03/23/2021, EC0P12, dated 06/15/2021, EC0P15, dated 07/13/2022 and EC0P16, dated 10/07/2022. Findings include: On 07/05/2023 at approximately 8:30 a.m., Surveyor toured the provider's facility. Surveyor observed an activity schedule for June 2023, but was unable to locate a schedule for July 2023. On 07/05/2023 at approximately 8:50 a.m., Surveyor interviewed Resident 2. Surveyor asked about the facility's activity programming. Resident 2 stated s/he was unable to recall the last time the facility had an activity. Resident 2 stated, "I	N 427		

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N 427	Continued From page 15 don't remember anything happening in the past few weeks to months." Resident 2 didn't recall the last time the facility had activities staff. On 07/05/2023 at approximately 8:55 a.m., Surveyor interviewed Director B. Surveyor asked about the facility's activities. Director B stated the facility had a cookout and fireworks the day prior. Director B stated the facility had been without activities staff for quite a while, but had a new activity director being oriented. On 07/05/2023 at approximately 9:25 a.m., Surveyor interviewed Resident 1. Resident 1 stated there were fireworks going off near the building the night prior, but no cook out. Resident 1 stated s/he didn't recall activities ever occurring at the facility. On 07/05/2023 at approximately 10:05 a.m., Surveyor reviewed concern with Sales and Marketing E that the facility did not have an activity schedule posted or activities taking place. Sales and Marketing E stated the Surveyor set the facility up for failure by conducting complaint investigations the day after a holiday.	N 427		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by:	N 450		

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N 450	Continued From page 16 Based on observation and interview, the provider did not ensure a weekly menu was written and available to residents. The facility did not have a menu posted. Findings include: On 07/05/2023, Surveyor toured the provider's facility. Surveyor was unable to locate a menu posted throughout the facility. On 07/05/2023 at approximately 8:40 a.m., Surveyor interviewed Cook C. Cook C stated a menu was not posted because the facility was in between directors and working on getting things organized. Cook C stated residents knew that eggs was usually served for breakfast, along with either sausage, bacon or sausage and gravy. On 07/05/2023 at approximately 8:50 a.m., Surveyor asked Resident 2 how s/he knew what was served for meals. Resident 2 stated s/he usually asked the cook prior to meals because s/he was a picky eater. On 07/05/2023 at approximately 9:25 a.m., Surveyor asked Resident 1 how s/he knew what was served for meals. Resident 1 stated s/he knew "when the meal gets to the table." On 07/05/2023 at approximately 10:05 a.m., Surveyor reviewed concern with Sales and Marketing E that the facility did not have a menu posted for residents. Sales and Marketing E stated the Surveyor set the facility up for failure by conducting complaint investigations the day after a holiday. The provider did not ensure residents were provided a weekly written menu.	N 450		

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N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements,	N 454		

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N 454	Continued From page 18 any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure records were obtained when Resident 6 was sent to the hospital for shortness of breath. Findings include: On 07/05/2023, Surveyor conducted a complaint investigation alleging insufficient care at the facility resulted in a hospitalization. At approximately 11:00 a.m., Surveyor reviewed Resident 6's record. Resident 6 was admitted to	N 454		

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N 454	Continued From page 19 the provider's facility on 03/15/2019 with diagnosis of dementia. Resident 6's progress notes, dated 03/01/2023 to 07/05/2023, did not include documentation of Resident 6 being sent out at any point for a medical evaluation. At approximately 11:15 a.m., Surveyor requested any medical visit notes for Resident 6 from Sales and Marketing E. Surveyor was provided an email, dated 06/20/2023, from Director B to Resident 6's managed care organization that stated Resident 6 was sent out due to breathing problems. Sales and Marketing E stated Director A was attempting to locate records from the hospital. At approximately 12:30 p.m., Surveyor followed up with Sales and Marketing E, Director A and Director B regarding documentation of Resident 6's hospitalization. Surveyor voiced concern that Resident 6's record did not include documentation of Resident 6's change in condition, being sent to the hospital, return from the hospital or any new orders that occurred because of the hospitalization. Director A stated s/he was unable to locate a report. On 07/06/2023 at approximately 10:00 a.m., Surveyor received an After Visit Summary for Resident 6's hospitalization from Administrator G. Director A confirmed s/he requested the documentation from Resident 6's managed care organization.. The summary documented Resident 6 was seen in an emergency room for shortness of breath and a urinary tract infection. Resident 6 was prescribed Keflex. Resident 6 was sent out of the hospital for shortness of breath; however, the facility had no record of the incident.	N 454		

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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 ensure a living environment that was safe, clean, comfortable and homelike was provided. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P12, dated 06/15/2021 and EC0P15, dated 07/13/2022. Findings include: On 07/11/2023, Surveyor completed 2 complaint investigations alleging the facility was not kept clean. The following concerns were identified: Soiled Laundry: On 07/05/2023 at approximately 11:00 a.m., Surveyor observed soiled bedding on the floor in Resident 4 and Resident 5's room. Resident 5's room smelt strongly like urine. On 07/05/2023 at approximately 12:05 p.m., Surveyor shared concern that resident rooms had soiled linens on the floor with Caregiver F. Caregiver F agreed Resident 5's room smelt strongly like urine and stated it was likely from the soiled laundry on the floor. Caregiver F asked Caregiver D to address the concern.	N 481		

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N 481	Continued From page 21 Utensils: On 07/05/2023 at approximately 10:45 a.m., Surveyor interviewed Caregiver D, who voiced concern that the facility did not have enough utensils for residents. Caregiver D stated the facility only had 5-6 forks and 5-6 spoons, so not every resident had utensils for meals. Caregiver D stated s/he tried to serve breakfast in phases, so s/he could rewash and reuse the utensils. Surveyor then observed the utensil drawer had no spoons, forks or knives. Caregiver D stated all the utensils the facility had were currently in the dishwasher. On 07/05/2023 at approximately 12:00 p.m., Surveyor observed residents eating tacos, rice and grapes. Surveyor observed that 3 residents had yet to be served and the facility had 1 remaining utensil available, an adaptive fork. Surveyor updated Sales and Marketing E that caregivers didn't have enough utensils to use with lunch. Sales and Marketing E followed up with Cook C. On 07/05/2023 at approximately 12:30 p.m., Surveyor reviewed concern that the facility did not have enough utensils for residents. Sales and Marketing E replied, "It's because staff are too lazy to wash [utensils]. [Caregivers] just throw [utensils] away." Sales and Marketing E stated Cook C was ordering additional utensils. Garbage: On 07/05/2023 at approximately 11:00 a.m., Surveyor observed 4 garbage bags piled up in the facility's entry way. Surveyor asked Director B why the garbage was piled up. Director B stated	N 481		

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N 481	Continued From page 22 garbage was piled up because only 1 caregiver was present and the caregiver couldn't leave residents unattended. Surveyor observed 2 caregivers and several administrative staff present from approximately 9:00 a.m. to 11:00 a.m. Food Storage: On 07/05/2023 at approximately 8:40 a.m., Surveyor toured the facility's kitchen. Surveyor observed 2 bags of onions stored on the floor, a full garbage bag on the floor and food debris and remnants on the surfaces of appliances. Cook C stated Surveyor caught him/her at a bad time. Cook C stated s/he just finished breakfast and putting a truckload away. Cook C stated s/he had started at the facility approximately 4 weeks ago and was still getting the kitchen cleaned and organized. On 07/05/2023 at approximately 12:30 p.m., Surveyor reviewed environmental concerns with Sales and Marketing E, Director A and Director B. All individuals made note of Surveyor's concern.	N 481		
N 487	83.44(1)(b) Separate laundry storage areas or containers Storage and transport. The CBRF shall have separate clean and dirty laundry storage areas or containers. Storage containers shall be clean, leak-proof and have a tight fitting lid. The CBRF may not transport, wash or rinse soiled laundry in areas used for food preparation, serving or storage. This Rule is not met as evidenced by: Based on observation and interview, the provider	N 487		

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N 487	Continued From page 23 did not ensure separate storage areas or containers were provided for clean and soiled laundry. Findings include: On 0711/2023, Surveyor completed a complaint investigation that laundry was not conducted in a sanitary manner. On 07/05/2023 at approximately 10:00 a.m., Surveyor observed Caregiver D carry soiled laundry without any sort of container. The laundry was held to his/her chest with his/her gloved hands. Surveyor then observed Caregiver D had placed the soiled laundry on top of the facility's dryer. Surveyor asked Caregiver D if the provider had separate storage areas and containers for soiled and clean laundry. Caregiver D explained that some residents don't have any baskets, so s/he just carried the laundry. Caregiver D stated s/he placed the soiled laundry on the dryer because there were clean clothes in the washer waiting to be dried, but the dryer was in use and took multiple cycles to dry. Caregiver D stated with the dryer taking multiple cycles to dry, s/he was only able to complete about 2 loads of laundry per shift. On 07/05/2023 at approximately 10:05 am., Surveyor shared concern that not all residents had containers for soiled and clean laundry, Sales and Marketing E replied, "We have to provide laundry baskets?" Surveyor then discussed sanitation concern with caregivers carrying laundry back and forth from resident rooms. Sales and Marketing E made note of the concern.	N 487		

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N 499	Continued From page 24	N 499		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure toxic chemicals were stored in a secured area. Detergent and cleaning agents were accessible to residents. This is a repeat deficiency. See Statement of Deficiency (SOD) EC0P12, dated 06/15/2021, EC0P13, dated 10/05/2021 and EC0P14, dated 03/29/2022. Findings include: On 07/05/2023 at approximately 8:30 a.m., Surveyor toured the provider's facility. Surveyor observed the provider's laundry room door was propped completely open. Inside the laundry room was laundry detergent, which was accessible to residents. Surveyor then observed the provider's linen/cleaning closet, which had a sign that stated "This door needs to be locked at all times," was unlocked and accessible. The linen/cleaning closet contained toilet cleaner and all-purpose cleaner. On 07/05/2023 at approximately 10:05 a.m., Surveyor reviewed concern with Sales and Marketing E that the facility did not have toxic chemicals secured. Sales and Marketing E stated s/he had ensured there were locks throughout the facility due to previous deficiencies. Surveyor acknowledged that both the laundry room and	N 499		

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N 499	Continued From page 25 linen/cleaning closet had locks, but the locks were not engaged. Sales and Marketing E stated the Surveyor set the facility up for failure by conducting complaint investigations the day after a holiday.	N 499		