STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019869	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR MEMORY CARE ASSISTED LIVING OF	1936 TENNYSON LN MADISON, WI 53704

(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 From 06/17/2024 to 06/21/2024, Surveyors conducted 4 complaint investigations, 3 self-report reviews, 2 verification visits and a standard survey at Bay Harbor Memory Care Assisted Living of Madison, a CBRF in Madison. Seventeen deficiencies were identified. One deficiency was a repeat deficiency - See Statement of Deficiency (SOD) CJWV11, dated 02/13/2024. Two complaints were substantiated. Two complaints were unsubstantiated. Three of 3 self-reports resulted in deficiencies. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 52	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form	N 158		

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

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N 158	Continued From page 1 provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure immediate steps were taken to ensure the safety of all residents upon learning of a report of neglect and that neglect was reported to the department within 7 days from the date the CBRF learned of the abuse. The provider allowed caregivers to continue working while being investigated for resident neglect. Once the investigation was concluded on 05/31/2024, the provider did not submit a caregiver misconduct report within 7 days. Findings include: From 06/17/2024 to 06/21/2024, Surveyor conducted a self-report review regarding Resident 7's fall. On 06/17/2024 at approximately 11:00 a.m., Surveyor reviewed Resident 7's record. Resident 7 was admitted to the provider's facility on 12/06/2021. Resident 7's record included the following documentation related to a fall and allegation of neglect: - Facility Progress Note, 05/25/2024 4:15 a.m.: Resident was yelling out for help. Staff found him/her on the floor completely naked. Staff assisted resident back to bed. Called hospice and on-call director. - Facility Progress Note, 05/25/2024 6:30 a.m.: At 4:00 a.m. staff heard resident yell for help. Staff	N 158		

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N 158	Continued From page 2	N 158		

went into room and found resident on the floor next to his/her recliner completely naked. Hospice was called and sent a nurse to the facility at 4:30 a.m.
- Incident Report, 05/25/2024 4:05 a.m.: Unwitnessed fall. Report identified a gash on the outside of Resident 7's left bicep and hospice was coming to complete assessment. Report documented facility caregivers did not check vitals or question about pain.
- Self-Report, dated 06/05/2024: Resident had a fall that was detected by the [fall detection camera] in his/her room on 05/25/2024. On 05/26/2024, it was relayed to shift lead, by family who had their own camera in Resident 6's room, that the fall actually occurred on 05/24/2024 at 11:45 p.m. but staff were not seen entering the room until 4:00 a.m. Both employees were termed, and the provider was filing a Caregiver Misconduct for each employee. Hourly checks put into place.
- Investigation: On 05/25/2024, Executive Director I received a call stating Resident 7 had a fall and was left unattended. Resident 7's family requested to meet 05/27/2024. On 05/26/2024, Executive Director I was informed by shift lead that Resident 7's family sent video footage showing duration Resident 7 was on the ground. On 05/27/2024, Executive Director I met with Resident 7's family to explain action plan. On 05/31/2024, both employees involved with fall were terminated following investigation and interviews.

Surveyor identified the following concerns regarding the provider's handling of an allegation of neglect:

- Reporting: On 06/17/2024 at approximately 2:40 p.m., Surveyor interviewed Administrator A,

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N 158	Continued From page 3 Executive Director I, LPN F and Chief Operating Officer H regarding Resident 7's fall. Administrator A stated staff did observe footage and confirmed Resident 7 sustained a fall at approximately 11:45 p.m., but staff did not respond until approximately 4:00 a.m. Administrator A stated both caregivers were terminated and the facility was still working on submitting a caregiver misconduct report. Surveyor shared concern that the fall happened on 05/25/2024 but that a caregiver misconduct report had not been submitted as of 06/17/2024. Administrator A nodded his/her head in agreement with Surveyor's concern. Chief Operating Officer H stated s/he would help with submitting the report. - Ensuring Safety of Residents: On 06/19/2024 at approximately 3:20 p.m., Surveyor asked Administrator A what the provider did to ensure the safety of residents upon learning of the allegation of abuse. On 06/20/2024 at approximately 2:00 p.m., Administrator A responded to Surveyor and stated the 2 employees involved with the 05/24/2024 incident were terminated and hourly checks were put into place. The provider's employee schedule documented Caregiver K worked 05/26/2024, 05/28/2024 and 05/29/2024 and Caregiver L worked 05/27/2024 and 05/28/2024, indicating the provider allowed caregivers to continue to work after being made aware of neglect allegations.	N 158		
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	N 164		

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N 164	Continued From page 4	N 164		

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 a written report was submitted to the department within 3 working days after law enforcement personnel were called to the CBRF as a result of an incident that jeopardized the health, safety and welfare of residents and employees. The provider did not submit a self-report to the department when law enforcement responded to the facility for Resident 8's behaviors.

Findings include:

On 06/19/2024 at approximately 2:00 p.m., Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider's facility on 05/02/2024 with diagnosis of dementia with behavioral disturbance. Resident 8's record included an incident report, dated 06/15/2024, that stated "Resident was taking objects from [his/her] room ... and throwing them at staff. The vase broke and shattered glass across the floor hitting staff and another residents' feet. [S/he] threw [his/her] deodorant at staff right in the square of the back. Threw [his/her] dinner plate at staff which shattered on the floor and got food all over staff. Redirection to [his/her] room only works for 5 minutes at a time before [s/he] comes out trying to throw something else or ram staff

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N 164	Continued From page 5 with [his/her] walker. ... Staff called 911 for care unit. Was not responding to this and kept throwing things at the officers as well as hitting them." On 06/19/2024 at approximately 3:00 p.m., Surveyor reviewed department records and was unable to locate a self-report submitted by the provider regarding law enforcement being at the facility for the health, safety and welfare of Resident 8 and others. On 06/19/2024 at approximately 3:20 p.m., Surveyor asked Administrator A if a self-report had been submitted to the department regarding Resident 8's behaviors on 06/15/2024. On 06/20/2024 at approximately 2:00 p.m., Administrator A did not have a self-report to provide. Administrator A stated, "Moving forward staff will be directed to notify the Director of Operations whenever police are on the premises."	N 164		
N 172	83.12(6) Documentation requirements for written report All written reports required under this section shall include, at a minimum, the time, date, place, individuals involved, details of the occurrence, and the action taken by the provider to ensure residents ' health, safety and well-being. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure investigations of alleged misconduct included, at the minimum, the time, date, place, individuals involved, details of the occurrence and the action taken by the provider	N 172		

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to ensure the health, safety and well-being of residents. The provider did not have detailed documentation of investigations for an allegation of neglect and allegation of theft.

Findings include:

From 06/17/2024 to 06/20/2024, Surveyor conducted a complaint investigation alleging theft and a self-report review alleging caregiver neglect. Surveyor identified the following concerns with the provider's investigations:

Example 1 - Allegation of Neglect:

On 06/17/2024, at approximately 11:00 a.m., Surveyor reviewed Resident 7's record. Resident 7 was admitted to the provider's facility on 12/06/2021. Resident 7's record included documentation of a fall on 05/25/2024, which caregivers responded to at approximately 4:05 a.m. Resident 7's record included a self-report, dated 06/05/2024, that documented camera footage, provided by Resident 6's family, indicated Resident 6's 05/25/2024 fall actually occurred on 05/24/2024 at 11:45 p.m. but staff were not seen entering the room until 4:00 a.m.

On 06/17/2024 at approximately 2:40 p.m., Administrator A stated the provider conducted an investigation and was working on submitting a Caregiver Misconduct Report for the 2 caregivers involved with Resident 6's fall. Administrator A stated the caregivers had been terminated. Surveyor requested documentation of the provider's investigation.

On 06/17/2024 at approximately 4:00 p.m., Surveyor received documentation of the provider's investigation, completed by Executive

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N 172	Continued From page 7 Director I. The documentation did not include times, names of the caregivers involved, details of the occurrence or the action taken by the provider to ensure the health, safety and well-being of residents. Example 2 - Allegation of Theft: On 06/17/2024 at approximately 2:00 p.m., Surveyor asked Administrator A if s/he was aware of any allegations of theft in the past 3 months. Administrator A stated s/he would have to check with Executive Director I. On 06/17/2024 at approximately 2:40 p.m., Administrator A stated Resident 8 and/or his/her family had made an allegation of theft, but the allegations were not substantiated. Surveyor requested documentation of the investigation. On 06/17/2024 at approximately 4:00 p.m., Surveyor received the investigation. The investigation did not include dates or times, did not summarize what the investigation included and did not include details of the action taken by the provider to ensure the health, safety and well-being of residents. On 06/20/2024 at approximately 2:00 p.m., Administrator A updated Surveyor that the investigation occurred on 05/27/2024.	N 172		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel,	N 214		

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N 214	Continued From page 8 finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on observation, record review and interview, Administrator A did not provide the supervision necessary to ensure that residents received proper care and treatment, that their health and safety were protected and promoted and that their rights were respected. Findings include: From 06/17/2024 to 06/21/2024, Surveyors conducted 4 complaint investigations, 3 self-report reviews, 2 verification visits and a standard survey. The following concerns were identified: Environment: - The environment was not clean and homelike. Carpeting was soiled, walls had inappropriate writings and trim/walls needed repairs. - The provider did not have a horizontal evacuation plan. - The 2nd and 3rd floors of the facility did not have latching hardware that permitted opening from the inside with a one-hand, one-motion operation without the use of a key or special tool. - The provider did not ensure residents had the ability to lock their rooms.	N 214		

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N 214	Continued From page 9 Employees: - Employee background checks were incomplete. - One of 3 caregivers reviewed had not completed department approved training as required. - Three of 3 caregivers reviewed had not completed all employee training as required. Residents: - The provider did not complete a caregiver misconduct report within 7 days after substantiating neglect concerns or ensure the safety of residents while the investigation took place. - The provider did not report an incident that required law enforcement to report to the facility for the health, safety and welfare of a resident and staff. - The provider did not ensure investigations of allegations of neglect and theft were thoroughly documented and included details such as dates, times and who was involved. - The provider did not ensure 1 of 1 resident admissions reviewed was included a tuberculosis test completed within 90 days prior to admission or 7 days after admission. - The provider did not ensure a resident received prompt treatment after sustaining a fall. - The provider did not ensure a resident was reassessed after sustaining 9 falls. - The provider did not ensure a resident's legal representative was involved with the development of the resident's individual service plan (ISP). - The provider did not ensure resident ISPs were updated with changes of condition. - The provider did not ensure medication administration was accurately documented. - The provider did not ensure resident behaviors	N 214		

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N 214	Continued From page 10 were managed. On 06/17/2024 at approximately 2:40 p.m., Surveyors reviewed environmental, employee and resident care concerns with Administrator A, LPN F, Business Office Manager B, Health and Wellness J, Executive Director I and Chief Operating Officer H. All individual took note of Surveyors concerns. Administrator A commented, "We have work to do."	N 214		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a caregiver background check following the procedures in s. 50.054 and DHS 12 was completed for 2 of 3 caregivers. The provider did not complete out of state background checks for Caregiver C or Caregiver D, who resided out of state within 3 years of hire.	N 219		

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N 219	Continued From page 11 Findings include: On 06/18/2024 at approximately 10:00 a.m., Surveyor reviewed employee records provided by Business Office Manager B. Records documented the following: - Caregiver C was hired on 11/02/2023. Caregiver C's background information disclosure (BID) indicated s/he had resided in Illinois within the past 3 years. Caregiver C's record did not include a background check with the State of Illinois. - Caregiver D was hired on 02/28/2024. Caregiver D's BID indicated s/he had resided in Illinois within the past 3 years. Caregiver D's record did not include a background check with the State of Illinois. On 06/18/2024 at approximately 11:00 a.m., Surveyor asked Business Office Manager B if background checks were completed with the state of Illinois for Caregiver C and Caregiver D. On 06/18/2024 at approximately 12:35 p.m., Business Office Manager B stated s/he didn't have any other documentation to provide.	N 219		
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	N 239		

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N 239	Continued From page 12 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 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 1 of 3 employees obtained all department approved training as required. Caregiver D did not have training in first aid and choking within 90 days after starting employment. Findings include: On 06/17/2024 at approximately 10:00 a.m., Surveyor conducted a review of 3 employees to verify compliance with department approved training requirements. Surveyor requested training records from Business Office Manager B for Caregiver D. The record for Caregiver D, hired 02/28/2024, did not contain evidence of training or evidence of meeting an exemption for first aid and choking. On 06/17/2024, at approximately 12:35 p.m.,	N 239		

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N 239	Continued From page 13 Surveyor interviewed Business Office Manager B. Business Office Manager B confirmed the provider did not have evidence Caregiver D completed or met an exemption for first aid and choking training. On 06/17/2024 at approximately 1:00 p.m., Surveyor verified Caregiver D was not on the Community-Based Care and Treatment training registry for first aid and choking. On 06/17/2024 at approximately 2:40 p.m., Business Office Manager B stated Caregiver D was scheduled for first aid and choking training on 06/18/2024.	N 239		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group	N 243		

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N 243	Continued From page 14 served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure 3 of 3 employees reviewed, obtained all training as required within 90 days after starting employment. Caregiver C did not have training in resident rights within 90 days after starting employment. Caregiver E did not have training in recognizing, preventing, managing and responding to challenging behaviors within 90 days after starting employment. Caregiver E and Caregiver C did not have training in required client groups within 90 days after starting employment.	N 243		

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N 243	Continued From page 15 Findings include: On 06/17/2024 at approximately 10:00 a.m., Surveyor conducted a review of 3 employees to verify compliance with all employee training requirements. Surveyor requested training records from Business Office Manager B for Caregiver E, Caregiver C and Caregiver D.. Resident Rights The record for Caregiver C, hired 11/02/2023, did not contain evidence of training or evidence of meeting an exemption for resident rights. On 06/17/2024, at approximately 12:35 p.m., Surveyor interviewed Business Office Manager B. Business Office Manager B confirmed the provider did not have evidence Caregiver C completed or met an exemption for resident rights training. Recognizing, Preventing, Managing and Responding to Challenging Behaviors On 06/11/2024 at approximately 11:00 a.m., Surveyor reviewed resident records which indicated residents had a history of elopements, combativeness, refusing/resisting care, and calling 911 inappropriately. The record for Caregiver E, hired 01/02/2024, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. On 06/17/2024, at approximately 12:35 p.m., Surveyor interviewed Business Office Manager B. Business Office Manager B confirmed the provider did not have evidence Caregiver E completed or met an exemption for challenging behaviors training.	N 243		

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N 243	Continued From page 16 Client Group The facility was licensed to provide care and services to residents within the client groups of advanced age, irreversible dementia/Alzheimer's, physically disabled and emotionally disturbed/mental illness. The record for Caregiver E, hired 01/02/2024, and Caregiver C, hired 11/02/2023, did not contain evidence of training or evidence of meeting an exemption for client group training. On 06/17/2024, at approximately 12:35 p.m., Surveyor interviewed Business Office Manager B. Business Office Manager B confirmed the provider did not have evidence Caregiver E or Caregiver C completed or met an exemption for client group training specific to advanced age, irreversible dementia/Alzheimer's, physically disabled and emotionally disturbed/mental illness. The provider was given the opportunity to submit any additional evidence of training by end of day on 06/18/2024. No additional training documentation was received. Cross Reference: N0433 DHS 83.38(1)(i) Behavior Management	N 243		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the	N 302		

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N 302	Continued From page 17 screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 residents reviewed for admission procedures was screened for clinically apparent communicable disease, including tuberculosis. Resident 8 did not have a communicable disease screen completed prior to admission. Findings include: On 06/17/2024 at approximately 11:00 a.m., Surveyor reviewed resident records. Resident 8 was admitted to the provider's facility on 05/02/2024. Resident 8's record did not include a communicable disease screen. On 06/20/2024 at approximately 2:00 p.m., Administrator A followed up with Surveyor and confirmed Resident 8 did not have a communicable disease screen in his/her record. Administrator A stated the previous LPN was supposed to have read the results but Administrator A had no idea where the documentation was.	N 302		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment	N 353		

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N 353	Continued From page 18 In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 7 received prompt and adequate treatment that was appropriate to the resident's needs. Resident 7 sustained a fall on 05/24/2024 at approximately 11:45 p.m., but did not receive assistance from caregivers until 05/25/2024 at approximately 4:05 a.m. This is a repeat deficiency. See Statement of Deficiency (SOD) CJWV11, dated 02/13/2024. Findings include: From 06/17/2024 to 06/20/2024, Surveyor conducted a self-report review regarding a fall. On 06/17/2024 at approximately 11:00 a.m., Surveyor reviewed Resident 7's record. Resident 7 was admitted to the provider's facility on 12/06/2021. Resident 7's record included the following documentation: - Facility Progress Note, 05/25/2024 4:15 a.m.: Resident was yelling out for help. Staff found him/her on the floor completely naked. Staff assisted resident back to bed. Called hospice and on-call director. - Facility Progress Note, 05/25/2024 6:30 a.m.: At 4:00 a.m. staff heard resident yell for help. Staff went into room and found resident on the floor	N 353		

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N 353	Continued From page 19 next to his/her recliner completely naked. Hospice was called and sent a nurse to the facility at 4:30 a.m. - Incident Report, 05/25/2024: Unwitnessed fall. Report identified a gash on the outside of Resident 7's left bicep and that hospice was coming to complete assessment. Report documented facility caregivers did not check vitals or question about pain. - Facility Progress Note, 05/27/2024: Spoke with family and explained plan for adding leadership on every shift moving forward. - Medication Administration Record, dated 05/25/2024: PRN Acetaminophen administered at 3:16 p.m. - Self-Report, dated 06/05/2024: Resident had a fall that was detected by the [fall detection camera] in his/her room on 05/25/2024. On 05/26/2024, it was relayed to shift lead, by family who had their own camera in Resident 7's room, that the fall actually occurred on 05/24/2024 at 11:45 p.m. but staff were not seen entering the room until 4:00 a.m. Both employees were termed, and the provider was filing a Caregiver Misconduct for each employee. Hourly checks put into place. On 06/17/2024 at approximately 2:40 p.m., Surveyor interviewed Administrator A, Executive Director I, LPN F and Chief Operating Officer H regarding Resident 7's fall. Administrator A stated staff did observe footage and confirmed Resident 7 sustained a fall at approximately 11:45 p.m., but staff did not respond until approximately 4:00 a.m. Administrator A stated both caregivers were terminated and the facility was working on submitting a report to Office of Caregiver Quality regarding the 2 caregivers.	N 353		

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N 353	Continued From page 20 On 06/20/2024 at approximately 11:20 a.m., Surveyor reviewed a hospice note (obtained by Surveyor) that stated family reported they watched camera footage from the night of 05/24/2024 to 05/25/2024. Family reported Resident 7 fell at 11:49 p.m. when s/he was trying to disrobe. Family reported Resident 7 was wet from his/her urostomy leaking and attempting to disrobe. Family reported Resident 7 stood up and crumbled to the floor and lied on the floor from 11:49 a.m. until 4:02 a.m. when staff came into the room and found Resident 7 on the floor. Family reported Resident 7 yelled out the entire time s/he was on the floor, which was greater than 4 hours.	N 353		
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 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 1 of 5 residents reviewed had an assessment completed after sustaining multiple falls. Resident 6 did not have a fall assessment completed after sustaining 9 falls.	N 381		

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N 381	Continued From page 21 Findings include: On 06/17/2024 at approximately 11:00 a.m., Surveyor reviewed Resident 6's record. Resident 6 admitted to the provider's facility on 11/16/2023 with diagnosis of Parkinson's disease and unspecified psychosis. Resident 6's record included documentation of the following falls: - 03/19/2024 10:45 p.m.: Unwitnessed Fall - 03/21/2024 2:22 p.m.: Unwitnessed Fall - 04/14/2024 9:07 p.m.: Unwitnessed Fall - 05/07/2024 10:27 a.m.: Unwitnessed Fall - 05/18/2024 1:25 p.m.: Unwitnessed Fall - 05/22/2024 5:50 a.m.: Unwitnessed Fall - 05/22/2024 2:05 p.m.: Unwitnessed Fall - 05/29/2024 7:40 p.m.: Unwitnessed Fall - 06/08/2024 11:30 a.m.: Unwitnessed Fall - 06/09/2024 11:30 p.m.: Unwitnessed Fall - 06/11/2024 11:31 p.m.: Unwitnessed Fall - 06/16/2024 10:38 p.m.: Witnessed Fall On 06/17/2024 at approximately 12:00 p.m., Surveyor reviewed Resident 6's most recent fall assessment, dated 04/29/2024 and completed by Administrator A. The assessment listed fall prevention interventions as scheduled checks and call button/device/alarm. Surveyor noted 9 falls had occurred since Resident 6's fall assessment on 04/29/2024. Surveyor then reviewed Resident 6's individual service plan (ISP), dated 01/24/2024. The ISP stated "Resident's Needs: Mobility - Full Assist. Resident requires total assistance support including physical and verbal assistance with walking needs. Resident's level of assistance needs varies greatly throughout the day. At certain points most days resident is up independently moving about without aid/walker/with wheelchair.	N 381		

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N 381	Continued From page 22 At other times in the day resident needs full assist and at time is resistant to care and transfers." The ISP included hourly checks but did not address call button/device/alarm or any new interventions following the 04/29/2024 assessment. On 06/17/2024 at approximately 2:40 p.m., Surveyor reviewed concern with Administrator A, LPN F and Chief Operating Officer H that Resident 6 sustained 12 falls in the past 3 months, 9 of which were after Resident 6's most recent fall assessment. Chief Operating Officer H stated s/he would address the concern.	N 381		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by:	N 387		

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N 387	Continued From page 23 Based on record review and interview, the provider did not ensure 1 of 5 individual service plans (ISP) reviewed was developed with involvement from the resident's legal representative. Resident 6's ISP was not developed with his/her activated Health Care Power of Attorney (HCPOA). Findings include: On 06/17/2024 at approximately 11:00 a.m., Surveyor reviewed Resident 6's record. Resident 6 admitted to the provider's facility on 11/16/2023 with diagnosis of Parkinson's disease and unspecified psychosis. Resident 6 had an activated HCPOA. Resident 6's ISP had a print date of 06/17/2024, but was not signed. On 06/19/2024 at approximately 3:20 p.m., Surveyor asked for clarification regarding Resident 6's ISP development date and if it had been reviewed with Resident 6's HCPOA. On 06/20/2024 at approximately 3:20 p.m., Administrator A followed up with Surveyor and stated Resident 6's ISP was developed on 06/13/2024, but a meeting still needed to be held with Resident 6's HCPOA.	N 387		
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	N 389		

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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 ensure 3 of 5 individual service plans (ISP) reviewed were updated when there was a change in needs. Resident 7's ISP was not updated with fall interventions and the use of a fall detection camera. Resident 8's ISP was not updated with elopement interventions. Resident 11's ISP was not updated with his/her use of a fall detection camera.

From 06/17/2024 to 06/21/2024, Surveyor reviewed resident records and identified the following concerns with ISPs:

Example 1 - Resident 7:

On 06/17/2024 at approximately 11:00 a.m., Surveyor reviewed Resident 7's record. Resident 7 was admitted to the provider's facility on 12/06/2021. Resident 7's record included the following regarding falls:

- 03/17/2024: Unwitnessed fall in resident room. No injury. *Per progress note, asked hospice for bed alarm, but hospice does not provide alarms. No further intervention documented.
- 03/25/2024: Unwitnessed fall in resident room. Sustained bruise to right side of forehead. *Per progress note, bed should be kept in lowest position.

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- 05/25/2024: Unwitnessed fall in room. Sustained gash to left bicep. Self-report referenced use of a fall detection camera. *Per self-report, hourly checks put into place.

Surveyor then reviewed Resident 7's ISP, dated 02/13/2024, which documented the following regarding falls:

- Resident has an increased risk for falls due to not being oriented to their own ability.
- Resident is at a medium risk for falls due to his/her deficient of not knowing their own ability such as when using an assisted device and getting up without assistance.
- Goal: Resident will maintain a minimal risk of falling by prevention ideas until the next review.

Surveyor noted the ISP did not address fall interventions identified after falls sustained 03/17/2024 to 06/17/2024 and did not include the use of a fall detection camera.

On 06/17/2024 at approximately 2:40 p.m., Surveyor reviewed concern with Administrator A, Executive Director I, LPN F and Chief Operating Officer H that Resident 7's ISP was not updated to include all fall interventions and the use of a fall detection camera. Administrator A confirmed the provider had received consent to use the fall detection camera in Resident 7's room and made note to add it to Resident 7's ISP.

Example 2 - Resident 6:

On 06/17/2024 at approximately 11:00 a.m., Surveyor reviewed Resident 6's record. Resident 6 admitted to the provider's facility on 11/16/2023 with diagnosis of Parkinson's disease and unspecified psychosis. Resident 6's progress

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notes, dated 03/17/2024 to 06/17/2024, included the following:

- 05/24/2024: Resident tried to elope at 6:00 a.m. Staff writing note and overnight staff had to try to get resident back to the floor.
- 05/28/2024: Resident was found on the lower level of the building and returned to 2nd floor.
- 06/11/2024: Resident had eloped from facility with no supervision. Bystander called facility. Manager and LPN F tried to assist resident back to a car, but s/he resisted and a police officer was flagged down. Police assisted resident back to facility.

Surveyor reviewed Resident 6's ISP, dated 02/01/2024, included the following regarding elopement/wandering:

- Risk - Elopement - Resident's Needs: Resident has been identified as an elopement risk. Resident's Desired Outcome: To have proper precautions and redirection techniques in place to prevent elopement.
- Wandering - Full Assist - Directions: Resident needs complete supervision and redirection to avoid and prevent wandering/exit seeking episodes. Resident's Needs: Resident has exit-seeking behaviors which can lead to an elopement of an unplanned exiting of the facility without supervision. Resident's Desired Outcome: Resident desires to maintain low level of wandering episodes and the team to know the interventions to prevent constant exit seeking.
- Hourly Checks - Directions: Team member will conduct hourly checks.

On 06/19/2024 at approximately 3:20 p.m., Surveyor asked Administrator A if an assessment and new intervention was put into place after

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N 389	Continued From page 27 Resident 6's attempted and successful elopements. On 06/20/2024 at approximately 2:00 p.m., Administrator A provided Surveyor with an elopement assessment, dated 05/28/2024, that identified Resident 6 as an elopement risk. The assessment did not include interventions. Administrator A stated interventions were hourly checks (*repeat intervention), changing the door code and directing staff not to inform Resident 6's family member of the door code. On 06/20/2024 at approximately 2:30 p.m., Surveyor reviewed Resident 6's ISP and confirmed the ISP was not updated to include Resident 6's ability to learn the door code and the staff's directive not to share the door code with family. Example 3 - Resident 11 On 06/21/2024 at approximately 10:00 a.m., Surveyor reviewed Resident 11's record. Resident 11 was admitted to the provider's facility on 09/11/2023 with diagnosis of frontotemporal neurocognitive disorder. Resident 11's record included an incident report, dated 05/12/2024, that indicated s/he had a fall detected by a fall detection camera. On 06/21/2024 at approximately 1:30 p.m., Surveyor reviewed Resident 11's ISP, dated 02/14/2024, and noted the ISP was not updated to include Resident 11's use of a fall detection camera. On 06/17/2024 at approximately 2:20 p.m., Surveyor had shared concern that ISPs needed to be updated to include the use of fall detection	N 389		

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N 389	Continued From page 28 cameras and Administrator A had made note of the concern.	N 389		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the dosage of medication administered was documented for 2 of 2 residents reviewed that received sliding scale insulin. Resident 9's record included incorrect documentation of insulin administration. Resident 10's record did not include the number of insulin units administered. Findings include: On 06/17/2024 at approximately 11:00 a.m., Surveyor reviewed resident records. Example 1 - Resident 9: Resident 9 was admitted to the provider's facility	N 415		

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on 04/12/2023 with diagnosis of diabetes. Resident 9's physician orders included an order for Insulin Aspart 100 u/ml - Inject 4 units 3 times daily (Start Date: 05/15/2024). Resident 9's Medication Administration Record (MAR), dated 06/01/2024 to 06/17/2024, documented the incorrect dose of Insulin Aspart 100u/ml being administered on the following dates:

- 06/02/2024 6:57 p.m.: Documented 176 units of scheduled Aspart administered.
- 06/02/2024 11:49 a.m.: Documented 0 units of scheduled Aspart administered.
- 06/02/2024 4:20 p.m.: Documented 6 units of scheduled Aspart administered.
- 06/05/2024 7:07 a.m.: Documented 36 units of scheduled Aspart administered.
- 06/11/2024 7:41 a.m.: Documented 6 units of scheduled Aspart administered.
- 06/16/2024 11:17 a.m.: Documented 2 units of scheduled Aspart administered.

On 06/17/2024 at approximately 2:40 p.m., Surveyors interviewed Administrator A, Executive Director I, LPN F and Chief Operating Officer H regarding Resident 9's insulin administration. All individuals made note of Surveyors observations and believed the entries were documentation errors, not administration errors.

Example 2 - Resident 10:

Resident 10 was admitted to the provider's facility on 12/06/2021 with diagnosis of diabetes. Resident 10's physician orders included an order for Humalog 100u/ml (Start Date: 03/21/2024) - Use per sliding scale 4 times daily - 150-200=2u, 201-251=4u, 252-301=6u, 302-352=8u, 401-451=10u, 452-501=12u, If >500=Call MD. Resident 10's MAR, dated 05/01/2024 to

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N 415	Continued From page 30 05/30/2024, did not include documentation of the number of units of Humalog administered each. On 06/19/2024 at approximately 3:20 p.m., Surveyor shared with concern with Administrator A that Resident 10's MAR did not include documentation of the number of insulin units administered. On 06/20/2024 at approximately 4:40 p.m., Health and Wellness J followed up with Surveyor. Health and Wellness J stated the provider did not have the appropriate set up in the electronic record to prompt caregivers to document number of insulin units administered.	N 415		
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 record review and interview, the provider did not provide services to manage 2 of 5 residents reviewed. Resident 6 and Resident 8's record documented frequent behaviors. Findings include: On 06/17/2024 at approximately 11:00 a.m.,	N 433		

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N 433	Continued From page 31 Surveyor reviewed resident records and identified the following behavior management concerns: Example 1 - Resident 6: Resident 6 admitted to the provider's facility on 11/16/2023 with diagnosis of Parkinson's disease and unspecified psychosis. Resident 6's progress notes, dated 03/17/2024 to 06/17/2024, included the following: - 03/19/2024: Has been exit seeking most of the day, but staff have been able to redirect. - 03/21/2024: Not him/herself today. Kept throwing him/herself on the floor and didn't want to get up. - 03/25/2024: Refused to come out for meals, did not take medication and refused to let staff get him/her ready for the day. - 04/01/2024: Resident called 911 for assistance him/herself. Transported to ER. - 04/10/2024: Refused AM cares and would not eat breakfast. Hit staff while they were trying to assist him/her with incontinence cares. - 04/22/2024: Refused lunch and refused toileting assistance. - 04/29/2024 AM: Refused to get out of bed to use the bathroom. Screaming, crying and yelling. - 04/29/2024 PM: Going into other's rooms. - 05/16/2024: Refused all medications, cares and breakfast. - 05/21/2024: Refused medications and toileting assistance. - 05/24/2024: Tried to elope at 6:00 a.m. - 06/01/2024: Refused shower. - 06/02/2024: Called 911 3 times. - 06/03/2024: Poked at other residents, swung his/her wheelchair around, put self on the floor, wouldn't respond to staff and pushed staff out of his/her room to refuse help.	N 433		

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- 06/05/2024: Grabbed staffs' arms really tight, tried to choke staff while they are assisting with cares, poured a cup of water over his/her head, threw him/herself on the floor, threw chairs/walker/wheelchair around room, refused to use walker or wheelchair and refused medications.
- 06/07/2024: Lashed out at another resident hitting them in the head with a bowl. Lied unclothed on the floor. Tried to exit several times. Crawled on floor, hit and scratched staff. Went into other residents' rooms. Refused AM medications, dinner and cares.
- 06/09/2024: Refused cares and medications. Called EMS him/herself.
- 06/11/2024: Eloped from facility with no supervision. Bystander contacted facility. Staff attempted to assist resident back to the facility, but s/he refused so law enforcement assisted. Refused to take medications.
- 06/13/2024: Called 911 10x. When paramedics showed up resident didn't talk or respond to their questions.
- 06/14/2024: Refused AM cares.
- 06/15/2024: Pinched staff while trying to assist him/her off the floor.
- 06/16/2024: Called paramedics.
- 06/17/2024: Refused AM cares.

Resident 6's ISP, dated 02/01/2024, stated the following:
- "Behavior Tracking: Resident at times displays Behavioral Expressions ... Team will count the number of expressions the resident has each shift ... describe the behavior - what triggered the behavior and the interventions provided by the team and if they were effective. Suggestive interventions: 1. Offer to help resident get his/her hair/nails done following the task that is being requested ... 2. Be aware of non-verbal cues. I.E:

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SMILE, greet [him/her] politely when attempting care, medication administration. Staff should lower themselves in front of resident to make eye contact prior to care. Allow resident time to understand simple, short directives and to respond. 3. Resident enjoys art and wooden puzzles, use engagement opportunities to redirect and comfort resident during behavioral expression."
- "Aggressive/Combative - Monitor & Cue: Resident receives light monitoring and verbal prompting to avoid aggressive/combative episodes."
- "Behavior/Clinical Conference Call: The resident is on a behavior/clinical call bi-weekly with a Behavior Management Consultant along with the Nurse, Director of Operations, Auditing Director, and/or Director. PCP and/or Hospice will be notified to request medication adjustments or other treatments.
- "Destructive/Abusive - Partial Intervention: Monitor and cue resident closely. Assist in any preventative steps to avoid destructive/abuse behaviors. Redirect resident or contact appropriate provider for more assistance."
- "Risk - Elopement: Resident has been identified as an elopement risk ... Desired Outcome: To have proper precautions and redirection techniques in place to prevent elopement."
- "Wandering - Full assist: Resident needs complete supervision and redirection to avoid and prevent wandering/exit seeking episodes."

Resident 6's record did not include an updated behavior assessment.

On 06/17/2024 at approximately 2:40 p.m., Surveyor reviewed concern with Administrator A, LPN F and Chief Operating Officer H that Resident 6 exhibited ongoing behaviors from

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N 433	Continued From page 34 03/17/2024 to 06/17/2024; however, the provider did not have documentation of an updated assessment and new interventions or attempts to manage the behaviors. Administrator A stated Resident 6's behaviors were discussed on a biweekly clinical call but did not have examples or documentation to indicate the biweekly call was assisting with Resident 6's behavior management. Example 2 - Resident 8: Resident 8 admitted to the provider's facility on 05/02/2024 with diagnosis of dementia with behavioral disturbance. Resident 8's incident reports, dated 05/02/2024 to 06/17/2024, included the following: - 05/24/2024: Resident has been violent and has been pinching, scratching and running walker into staff. Gave resident PRN and s/he still hasn't calmed down. Tried to run walker into another resident. Resident family had to tell him/her to stop. - 05/25/2024: Resident grabbed staff by hair. Resident slapped staff. Staff was talking to another staff member when resident came up behind, choked and dug his/her nails in neck. Staff has scratches on his/her neck. - 05/25/2024: Resident hit staff numerous times, pinched staff, spit at staff, hit staff with walker, called staff names, pulled staff from behind, pulled staff's bra and tried to bite staff. - 05/26/2024: Slapped staff, called staff vulgar name and hit staff with walker. - 05/27/2204: Attempted to talk with resident about his/her behaviors. Resident grabbed staff's arm and hands trying to bend staff's fingers backwards. Resident scratched staff's forearm and started calling staff names. Resident started	N 433		

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walking into another staff member and hit the staff member with the walker on the back of legs and started pinching staff member in "[his/her] parts." When resident was redirected, s/he went to sit next to a resident and started to struggle with the resident about the remote, grabbing the resident by the arm.
- 06/15/2024: Resident hitting and slapping staff and other resident. Resident picking up walker and hitting others with it. Calling names.
- 06/15/2024: Resident was taking objects from his/her room and throwing them at staff. A vase broke and shattered glass across the floor hitting staff and another residents' feet. Resident threw his/her deodorant at staff right in the square of the back. Resident threw dinner plate at staff which shattered on the floor and got food all over staff. Redirection to his/her room only works for 5 minutes at a time before s/he came out trying to throw something else or ram staff with walker. Staff called 911. Resident was not responding and kept throwing things at the officers as well as hitting them.

Resident 8's ISP, dated 06/13/2024, stated the following regarding behaviors:

- "Behavior Tracking: Resident at times displays challenging behaviors ... Team will count the number of behaviors resident has each shift and document the number and team will describe the behavior - what triggered the behavior and the interventions provided by the team an if they were effective. Suggestive interventions: 1. 2. 3." *No interventions listed.
- "Aggressive/Combative - Full Intervention: The team constantly supervises and assists resident in redirecting aggressive/combative episodes. Notifies appropriate providers if needed ... Resident Needs: Resident receives complete

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assistance and aiding in alleviating aggressive/combative episodes thru redirection (List 3 interventions)." *No interventions listed.
- "Behavior/Clinical Conference Call: The resident is on a behavior/clinical call bi-weekly with a Behavior Management Consultant along with the Nurse, Director of Operations, Auditing Director, and/or Director. PCP and/or Hospice will be notified to request medication adjustments or other treatments.
- "Destructive/Abusive - Partial Intervention: Monitor and cue resident closely. Assist in any preventative steps to avoid destructive/abuse behaviors. Redirect resident or contact appropriate provider for more assistance."
- "Risk - Elopement: Resident has been identified as an elopement risk ... Desired Outcome: To have proper precautions and redirection techniques in place to prevent elopement."
- "Wandering - Full assist: Resident needs complete supervision and redirection to avoid and prevent wandering/exit seeking episodes.
*The ISP did document under tab "Using A PRN Psychotropic medication": PRN psychotropic medication use (no documentation of what medication) for anxiety, restlessness, pacing and/or worrisome. The ISP listed interventions prior to PRN use as starting up a conversation, looking at a magazine, redirecting conversation, watching tv, crafts, calling family or other distraction.

Resident 8's record did not include an updated behavior assessment.

On 06/19/2024 at approximately 3:20 p.m., Surveyor shared concern with Administrator A that Resident 8 had frequent behaviors and documentation did not indicate management of the behaviors.

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N 433	Continued From page 37 On 06/20/2024 at approximately 2:20 p.m., Administrator A stated Resident 8's ISP would be updated.	N 433		
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 the environment was safe, clean, comfortable and homelike. Carpeting was not clean, trim/walls were damaged and statements from a resident were written on the walls. Findings include: On 06/17/2024 at approximately 8:30 a.m., Surveyor toured the provider's facility and identified the following concerns: - Resident 4's carpeting had dark gray stains covering much of the room (Photo 6). The room smelt strongly of urine. Resident 4 wasn't sure if his/her carpeting had ever been cleaned. - Resident 5's wall in his/her hallway was scraped with drywall missing (Photo 5). The trim in the bathroom was missing (Photo 4). Resident 5 stated the damage occurred from his/her power chair. - The walls in the 4th floor common area included	N 481		

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N 481	Continued From page 38 the following statements written in marker: "I was abused at [another provider]. This facility is not safe for seniors," "List of Demands: I will be served fresh oranges on a week. I will be allowed to shave my facial - under supervision. I am not responsible for any damages" and "Please read _____ PS. I will not accept any correspondence or communication from my evil sister" (Photo 1, Photo 2, Photo 3). On 06/17/2024 at approximately 2:40 p.m., Surveyor reviewed environmental concerns with Administrator A. Administrator A wrote down' Surveyor's concerns. Administrator A stated s/he was unaware additional statements had been written on the wall on the 4th floor. Administrator A stated the statements should have been painted over immediately.	N 481		
N 527	83.47(2)(f) Horizontal evacuation. Horizontal evacuation. The CBRF shall have approval from the department before including horizontal evacuation in the emergency and disaster plan. CBRFs using horizontal evacuation shall document the total evacuation time of the fire zone evacuated. This Rule is not met as evidenced by: Based on observation, interview, and record review the provider did not have approval from the department before including horizontal evacuation in the emergency and disaster plan. The provider had no documentation of the total time of the fire zone evacuated. On 06/17/2024 at approximately 10:30am Surveyor toured the facility with Maintenance Director G. Surveyor exited the elevator onto the	N 527		

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second-floor landing and opened a door to the right of the landing that led to the unit that housed residents. Once inside the unit, Surveyor observed that the emergency exit diagram posted on the wall indicated that the main emergency exits were located behind egress fire doors located at the end of each hallway. The emergency exit led to a stairwell with a landing that was observed to be not large enough in size to accommodate more than one nonambulatory resident. Surveyor asked Maintenance Director G what nonambulatory residents who were unable to navigate the stairs to safety and who would not fit on the landing behind the fire door were to do in the event of an emergency. Maintenance Director G was unsure what would be done, did not know which residents would be point of rescue, and agreed that the space on the first landing behind the fire doors would not accommodate residents on the unit that would need to horizontally evacuate. Maintenance Director G confirmed that the evacuation plan was the same for 3 out of four floors of the CBRF.

On 06/18/2024 at 1:00pm Surveyor reviewed the emergency evacuation plan submitted via email by Business Office Manager B. Surveyor noted that within the plan there were no details or approval pertaining to horizontal evacuation. Surveyor asked Business Office Manager B how many wheelchairs or nonabulatory residents the stairwells will accommodate safely and what the plan was for the other residents who would need to evacuate behind the fire door.

On 06/18/2024 at 5:30pm Business Manager B replied, "I understand that the stairwells are limited on space. The doors to the waiting area of the elevators are also a firedoor. I also look forward to having our fire inspector come and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019869	A. BUILDING: _____ B. WING _____	R-C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY HARBOR MEMORY CARE ASSISTED LIVING OF	1936 TENNYSON LN MADISON, WI 53704

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N 527	Continued From page 40 help us with the appropriate evacuation plan. Attached is an evacuation plan that I have been working on that goes into much more depth of evacuation procedures." On 06/19/2024 Surveyor reviewed the more in-depth evacuation plan submitted by the provider. The plan did not detail documentation of the total time of the fire zone evacuated or an approved horizontal evacuation plan. Surveyor also noted that the doors to the waiting area of the elevators Business Manager B referenced in previous communication as fire-doors were the same doors that were observed to be locked from the inside of the unit preventing any person without a key or the pin pad code from exiting the unit to safety behind that particular fire door. CROSS REFERENCE 0639 83.59(2)(a) One-Hand, One-Motion Door Operation	N 527		
N 639	83.59(2)(a) One-hand, one-motion door operation All doors shall have latching hardware to permit opening from the inside with a one-hand, one-motion operation without the use of a key or special tool. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure all doors had latching hardware to permit opening from the inside with a one-hand, one-motion operation without the use of a key or special tool. The doors to the unit on the second and third floor, nearest the elevators, could not be opened without the use of a key or numerical code once inside the unit creating a locked unit. On 06/17/2024 at approximately 10:30am Surveyor toured the facility with Maintenance	N 639		

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N 639	Continued From page 41 Director G. Surveyor exited the elevator onto the second-floor landing and opened a door to the right of the landing that led to the unit that housed residents. Once inside the unit Surveyor allowed the door to shut behind them and then attempted to open the door again to exit the unit and go back to the elevator landing. After 30 seconds of applying pressure to the door and attempting to open the door and exit the unit, Surveyor was unsuccessful. Surveyor observed a lock on the door handle and a numerical pin pad on the wall beside the door. Surveyor asked Maintenance Director G how to exit the unit since the door would not open. He/she replied to exit a code needed to be entered into the pin pad or a fob or key would need to be utilized. Maintenance Director G confirmed that without assistance from him/her, Even Surveyor would be locked on the unit. Surveyor asked if any resident is given the code to the pin pad or a key/fob. Maintenance Director G replied, "No". On 06/17/2024 at approximately 10:45am Surveyor toured the facility with Maintenance Director G. Surveyor exited the elevator onto the third-floor landing and opened a door to the right of the landing that led to the unit that housed residents. Once inside the unit Surveyor allowed the door to shut behind them and then attempted to open the door again to exit the unit and go back to the elevator landing. After 30 seconds of applying pressure to the door and attempting to open the door and exit the unit, Surveyor was unsuccessful. Surveyor observed a lock on the door handle and a numerical pin pad on the wall beside the door. Surveyor asked Maintenance Director G how to exit the unit since the door would not open. He/she replied to exit a code needed to be entered into the pin pad or a fob or key would need to be utilized. Maintenance	N 639		

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N 639	Continued From page 42 Director G confirmed that without assistance from him/her, Even Surveyor would be locked on the unit. Surveyor asked if any resident is given the code to the pin pad or a key/fob. Maintenance Director G replied, "No". On 06/17/2024at approximately 3:00pm, Surveyor shared observations of the locked doors during the exit conference. Surveyor asked how residents on unit two and three would evacuate during an emergency if they were unable to navigate the stairwell that lay beyond the two egress doors identified as emergency exits and the door leading to the elevator was locking them into the unit. Administrator A did not have a response but confirmed that the doors were unable to be opened from the inside with one-hand one motion. CROSS REFERENCE N0527 DHS 83.47(2)(f) Horizontal Evacuation	N 639		