STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011954	A. BUILDING: _____ B. WING _____	C 06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS STEVENS POINT 2	3349 BUILDING B WHITING AVENUE STEVENS POINT, WI 54481

(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 06/06/2024 with additional information gathered through 06/10/2024, Surveyor conducted a desk review into one complaint for Care Partners Stevens Point 2. As a result the complaint was substantiated and one deficiency was identified. Census: 10	N 000		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not ensure a qualified resident care	N 397		

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

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N 397	Continued From page 1	N 397		

staff was present in the Community Based Residential Facility (CBRF) when one or more residents are present in the CBRF.

On 05/19/2024 at 6:23 AM, the SPFD (Stevens Point Fire Department) was dispatched to the facility for a lift assist for Resident 1 who was having trouble getting out of bed. Upon SPFD arrival there was no staff in the building. Former Caregiver E clocked out of work at 6:00 AM and left the facility, without another staff member present.

Findings include:

Care Partners Stevens Point 2 has had a regular Class CNA (non-ambulatory) CBRF license since 07/02/2007 for the capacity of 16 residents who are terminally ill, physically disabled, advanced aged, and/or have irreversible dementia/Alzheimer's disease. The facility is located on the same grounds as Care Partners Stevens Point 1 (a sister facility with a paved parking lot located between the two facilities). At the time of survey, 10 residents resided in the facility.

On 06/05/2024, the department received a concern regarding staff not being present in the CBRF on 05/19/2024.

On 06/05/2024, Surveyor interviewed Detective A from the SPPD (Stevens Point Police Department). Detective A indicated on 05/19/2024, the SPFD was called for a lift assist and there was no staff present in the building.

A Stevens Point Fire Department and Ambulance report dated 05/19/2024 at 6:23 AM indicated, "SPFD station 2 ambulance was dispatched to a

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N 397	Continued From page 2 CBRF for a lift assist for [Resident 1], who was having trouble getting out of bed. SPFD Med 2 responded immediately. Upon arrival, there was staff coming into the building. We met with them. They stated that an employee there "neglected the residents and then left." The staff we were speaking with stated they did not know what exactly was going on with the situation that we were called for because they had just gotten there, but they had an idea. They then took us to room 13. There, we found [Resident 1], with [his/her] upper torso lying flat in the middle of the bed and his/her legs hanging off the edge. The resident stated [s/he] needed help. Staff assisted us in helping the resident up to [his/her] feet. [Resident 1] then complained of back pain and stated [s/he] wanted to lay in bed ...[Resident 1] was alert and oriented and was reported to be [his/her] own person. The resident was then laid in bed in a comfortable position. SPFD Med 2 then cleared the scene becoming available for call ..." On 06/06/2024, Assistant Chief of EMS (Emergency Medical Services)-B provided Surveyor with the above SPFD report and a statement from Paramedic-H who responded to the scene. Paramedic-H stated, "On the morning of 05/19/2024, I and the EMS crew responded for a resident in need of a lift assist. Upon our arrival no staff was noted to be in the building. We met with the resident in [his/her] room who just needed help to a standing position due to chronic issues ...The call was successfully completed with ease and the resident was left satisfied...Staff from the opposite building that were off duty came to help and informed me the caregiver that was supposed to be there called 911 and left to go elsewhere leaving the building and other residents uncared for."	N 397		

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N 397	Continued From page 3 On 06/06/2024, Surveyor sent Regional Registered Nurse C the above SPFD report regarding staff not being present in the building during the morning of 05/19/2024. Surveyor requested information regarding this report. On 06/06/2024, Regional Registered Nurse C responded via email, "I'm forwarding this to [Director D]. [S/he'll] be the best point of contact for this." On 06/10/2024 at 1:00 PM, Surveyor interviewed Director D regarding the above SPFD report. Director D explained s/he had taken over the position of Director on 05/13/2024. Director D stated, "I was not aware of an ambulance being called to building 2. I was only aware of [Former Caregiver E] leaving building 2 unattended. I was called by staff [Caregiver F and Caregiver G] who was working in building 1 stating [Former Caregiver A] had left without anyone being there to relieve [her/him]. [Former Caregiver E] was working alone in building 2 and was supposed to work until 10 AM but didn't fulfill [her/his] whole shift. [Former Caregiver E] clocked out and left the building around 6:15 AM because "[S/he] had plans." After [Former Caregiver E] left building 2, [s/he] went over to building 1, handed the medication keys to staff [Caregiver F], and left. There were 2 staff [Caregiver F and Caregiver G] working in building 1. I asked one of them to go over and attend to building 2 until I could find a replacement. I was able to get two staff from the night shift to come into work at 7 AM." Director D went on to say, "[Former Caregiver E] was terminated following this incident...[Former Caregiver E] shouldn't left the building unattended." Surveyor then asked Director D how long building 2 was left unattended, without staff being present. Director D stated, "Maybe 5	N 397		

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N 397	Continued From page 4 minutes." On 06/10/2024 at 3:45 PM, Surveyor interviewed Caregiver F regarding the above incident. Caregiver F indicated s/he remembered the incident and stated, "I was working the day shift on 05/19/2024 in building 1 with [Caregiver G]. [Former Caregiver E] was working alone in building 2. [Former Caregiver E] left because [s/he] didn't want to stay at work. [Former Caregiver E] was tired and said [s/he] didn't want to work another shift and just left ...I then went over to building 2 and [Caregiver G] stayed in Building 1." An Employee Separation Statement for Former Caregiver E dated 05/20/2024 indicated, "Last Day Worked: 05/18/2024, Date of Termination: 05/20/2024. Reason for termination: Terminated by management- Reason: Abandoning residents and building without anyone to replace ..." Former Caregiver E's Employee Timesheet indicated s/he clocked into work on 05/18/2024 at 10:00 PM and clocked out of work on 05/19/2024 at 6:00 AM. The facility had no staff in the building when Former Caregiver E clocked out of work on 05/19/2024 at 6:00 AM and left. At 6:23 AM, the SPFD was dispatched to the facility to assist Resident 1 who was having trouble getting out of bed.	N 397		