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	0018757	A. BUILDING: _____ B. WING _____	C 07/13/2023

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N 000	Initial Comments On 06/27/2023, Surveyor conducted a probationary standard survey and investigated 2 complaints and 3 self-reports at Vitacare Living Spooner I. Data was collected through 07/13/2023. Five violations were identified. One complaint was substantiated. One complaint was unsubstantiated. Census: 10.	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 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:	N 158		

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

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Based on record review and interview, the provider did not ensure an investigation of staff that allegedly verbally abused a resident was reported to Department within 7 days.

Findings include:

The provider is licensed to care for 18 residents in the client groups developmentally disabled and physically disabled.

On 06/08/2023, the Department received a self-report that stated on 05/25/2023, Operations Manager (OM) B had received a call from the program and overheard Care Specialist (CS) E repeatedly yelling at Resident 4. OM B directed staff to separate CS E from Resident 4 and CS E was suspended the following day pending an investigation.

On 06/27/2023 at approximately 9:30 AM, Surveyor interviewed Executive Director (ED) C. ED C stated there was an issue with CS E because s/he yelled at Resident 4 and a self-report had been submitted to the Department.

At approximately 1:07 PM, OM B stated s/he investigated the event and sent it to their human resource department. OM B confirmed that the self-report received by the Department was the completed report of the investigation.

On 07/11/2023 from 10:05 AM to 11:40 AM, Surveyor interviewed OM B. OM B stated s/he was not aware the report had to be submitted within a certain period of time.

On 07/12/2023 from 2:57 PM to 3:36 PM, Surveyor interviewed OM B and Executive

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N 158	Continued From page 2 Director (ED) C. ED C stated that moving forward, staff would be directed to complete reports within 72 hours and s/he was working on registering for the Misconduct Incident Reporting (MIR) system. The provider did not ensure a self-report was sent to the Department within 7 days of the incident.	N 158		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure adequate supervision for Resident 1, who had a history of elopement. Findings include: The provider is licensed to care for 18 residents in the client groups developmentally disabled and physically disabled. On 05/01/2023, the department received a self-report that stated, "Staff were administering meds when they noticed that [Resident 1] had	N 426		

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wandered off ...When staff searched outside the building they found [Resident 1] on the hill." The report did not include information on how long Resident 1 was gone.

On 06/27/2023 at 8:30 AM, Surveyor entered the program, heard the front doorbell engage and ring once, and waited for approximately 5 minutes. Staff did not come to the front door to check why the front door alarm engaged.

At approximately 8:35 AM, Surveyor interviewed Executive Director (ED) C and Operations Manager (OM) B. ED C stated staff were supposed to check when the front door alarm engaged and confirmed there were 2 other staff working.

At approximately 11:27 AM, Surveyor interviewed Care Specialist (CS) A. CS A stated s/he thought the front door currently had a "ding alarm" but a new front door alarm had been installed that was continuous until staff shut it off. CS A stated the continuous front door alarm was currently disconnected because the resident with elopement risk had discharged. CS A stated that s/he can hear the current front door alarm in the kitchen.

At approximately 1:07 PM, Surveyor interviewed OM B. OM B stated the continuous front door alarm had been disengaged on 06/22/2023 because Resident 1, who was an elopement risk, discharged.

At 3:08 PM, ED C stated the continuous front door alarm was installed prior to admitting residents with elopement risks.

On 07/11/2023 from 10:05 AM to 11:40 AM,

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Surveyor interviewed ED C and OM B. ED C stated there was not a written procedure for the door alarms other than staff were to check when they engaged. ED C stated when Resident 1 eloped on 04/26/2023 s/he could not confirm if the front door alarm was engaged or not. ED C stated CS E was working during the elopement but s/he would not confirm if s/he had shut off the alarm.

From 12:54 PM to 1:14 PM, Surveyor interviewed CS D. CS D stated Resident 1 was an elopement risk and in March 2023, the continuous front door alarm was installed. CS D stated staff carried a key fob that could shut off the continuous alarm. CS D stated that sometimes the alarm did not work.

On 07/11/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted 12/15/2021 and diagnosed with dementia with behavioral disturbance, anxiety, hyperlipidemia, hypertension, and Type I Diabetes Mellites. Resident 1 was under guardianship.

On 07/11/2023, Surveyor reviewed Resident 1's individualized service plan (ISP), dated 3/08/2023, that read, in part, "Wander risk ...elopement risk ...3/20/2023 continuous monitor alarms on entry doors and bedrooms."

On 07/11/2023, Surveyor reviewed nurse's notes for Resident 1, dated 04/26/2023, that read, "PM ...Resident eloped [sic] checked all room [sic] looked through a window and seen [sic] [him/her]. Wasn't even out 5min [sic] on hill between buildings."

The provider did not ensure the safety of Resident 1 when s/he eloped, and it was unclear

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N 426	Continued From page 5 if staff checked when the continuous front door alarm engaged or if the alarm was shut off.	N 426		
N 439	83.39(1) Infection control program. The licensee shall establish and follow an infection control program based on current standards of practice to prevent the development and transmission of communicable disease and infection. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not follow an infection control program based on current standards of practice to prevent the development and transmission of communicable disease and infection. Findings include: The provider is licensed to care for 18 residents in the client groups developmentally disabled and physically disabled. On 06/27/2023 at approximately 11:45 AM, Surveyor observed Care Specialist (CS) A take Resident 5's blood sugar and administer insulin. CS A sanitized his/her hands, donned gloves, used keys to open the locked medication cart, and removed a red covered box. CS A explained that the glucometer, test strips, lancets, and medication were kept in the medication box and easier to take to the resident. CS A locked the medication cart, closed the medication room door, and walked to Resident 5's room where s/he opened the door. Resident 5 was sitting in a	N 439		

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N 439	Continued From page 6	N 439		

chair. CS A set the medication box on a side table, opened the box, and removed an alcohol pad. CS A opened the alcohol pad, removed the alcohol towelette and sanitized Resident 5's finger. CS A put the used packaging and the soiled alcohol pad in the box cover. CS A removed a test strip from the container and inserted the test strip into the blood sugar meter. CS A removed the covering from a lancet and pricked Resident 5's finger. CS A put the soiled lancet in the cover of the box cover. CS A then touched the end of the test strip in the blood droplet. CS A removed the soiled test strip and put in the box cover. CS A picked up the soiled alcohol pad and wiped an area on Resident 1's stomach to prepare for the Novolog injection.

At approximately 2:00 PM, CS A stated that s/he knew s/he should have donned the gloves after s/he entered Resident 5's room, realizing that s/he touched multiple surfaces.

From 2:18 PM to 3:21 PM, Surveyor interviewed Executive Director (ED) C and Operations Manager (OM) B. ED C stated the staff were trained in standard precautions and audits occurred.

On 06/27/2023, Surveyor reviewed a document titled HANDWASHING/SANITIZING & GLOVE USE AUDIT that read, "Change gloves following handling of equipment or medication administration or touching."

The provider did not ensure their policy regarding gloves was followed when CS A touched multiple surfaces before administering blood sugar and insulin.

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N 443	Continued From page 7	N 443		
N 443	83.39(5) Pets vaccinated. The CBRF shall ensure that pets are vaccinated against diseases, including rabies, if appropriate. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 2 pets owned by a staff person, that were at the program on a regular basis, were vaccinated against rabies. Findings include: The provider is licensed to care for 18 residents in the client groups developmentally disabled and physically disabled. On 06/27/2023, Surveyor observed 2 medium-sized dogs roaming the building and sleeping in dining room chairs. At approximately 9:40 AM, Care Specialist (CS) A confirmed that s/he owned the dogs and often brought them to work. CS A stated the residents enjoyed having the dogs visit. On 06/27/2023, Surveyor reviewed 2 documents titled [FACILITY NAME] VETERINARY PRACTICE that read, "RABIES VACCINATION CERTIFICATE, date vaccinated 06/07/2019 and vaccination expires 06/06/2022." The Surveyor informed Operations Manager (OM) B that both dogs' rabies vaccinations were expired. On 07/11/2023, Surveyor interviewed Executive Director (ED) C and OM B. ED C stated CS A had not received a notification from the vet that the rabies had expired. ED C stated there was not a system in place to track the vaccinations but they would implement a system.	N 443		

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N 443	Continued From page 8 The provider did not ensure 2 dogs that regularly visited the facility were vaccinated against rabies when their rabies shots had expired approximately a year ago.	N 443		
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 clean environment. Findings include: The provider is licensed to care for 18 residents in the client groups developmentally disabled and physically disabled. On 06/08/2023, the Department received a complaint that read, " ...concerns that dead bugs were found in [Resident 2's] bed and knew that the provider had bed bugs ...concerns of the overall program cleanliness." On 06/27/2023 at approximately 8:30 AM, Surveyor observed 2 large flower planters at the entrance to the program full of dead plants and multiple weeds growing through the rock bedding that surrounded the building. At approximately 9:00 AM, Surveyor interviewed	N 481		

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Executive Director (ED) C. ED C stated there were bed bugs in the building that spread to Room 9, 10, and 11. ED C stated they were immediately treated and there had not been reports of bed bugs since the extermination.

At approximately 9:30 AM, Surveyor observed the dining room chairs and saw most of the cloth-covered dining room chairs were dirty and stained.

At approximately 1:50 PM, Surveyor observed dirty and stained carpet in Resident 3's room.

At approximately 2:00 PM, Surveyor toured Resident 2's bedroom and bathroom with ED C and Operations Manager (OM) B. Surveyor noted a urine smell in the bedroom and a strong urine smell in the bathroom. ED C stated they were aware of the urine smell but were unsure where the smell was originating. ED C stated the plan was to replace the toilet seat, replace the carpet, and fix the broken/stained grout in the floor tiles by the toilet. Surveyor observed the bathroom air vent was dirty.

On 07/10/2023 from 4:49 PM to 5:27 PM, Surveyor interviewed Resident 4's guardian. Guardian F stated s/he often found items and surfaces sticky, that the carpet needed to be replaced, and s/he had to change dirty sheets on Resident 4's bed. Guardian F was unable to provide dates.

On 07/11/2023 from 10:05 AM to 11:40 AM, Surveyor interviewed ED C and OM B. ED C stated that in Resident 2's bathroom, they determined a shelving unit, made of partical board, had been soaked with urine, which was contributing to the smell and the shelf was to be

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N 481	Continued From page 10 replaced. ED C stated maintenance was currently in the building, measuring to replace Resident 2's carpet. From 12:54 PM to 1:14 PM, Surveyor interviewed Care Specialist (CS) D. CS D stated that staff cleaned Resident 2's room often because s/he had urine accidents. The provider did not ensure the program was clean.	N 481		