STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017703	A. BUILDING: _____ B. WING _____	R-C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF MADISON APPLEWOOD	5565 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 08/29/2024, with information gathered through 10/02/2024, the Bureau of Assisted Living, Southern Regional Office conducted a standard licensing survey, 2 complaint investigations, and a verification visit of statement of deficiency (SOD) OCCY11 at Cottages of Madison Applewood, located at 5565 Burke Rd in Madison, WI. 32 citations of noncompliance were issued, including 18 repeat citations of noncompliance. Two complaints were substantiated. Census: 10 Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed.	{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	N 158		

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

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misappropriation of property. The CBRF shall maintain documentation of any investigation.

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the provider did not ensure allegations regarding misappropriation of resident medication, including medications belonging to Resident 10 and Resident 9, were investigated, and documented.

On 07/23/2024, during the evening shift/3:00 P.M. to 11:00 P.M., Caregiver D observed Resident 10's sedative, hypnotic medication zolpidem prescribed to be administered at bedtime was missing from Resident 10's-unit dose packaging card for 07/23/2024 before bedtime medications were to be administered, and for 07/31/2024. At 7:07 P.M., Caregiver D reported an allegation to House Manager B including Caregiver R administering extra doses of Resident 10's sleep medication during the night shift/11:00 P.M. to 7:00 A.M. to control Resident 10's behavior during the night. Caregiver D also reported to House Manager B s/he removed Resident 10's zolpidem dose as originally packaged for 07/24/2024 and administered it to Resident 10 on the evening of 07/23/2024, since Resident 10's 07/23/2024 dose had already been removed. Caregiver D's documentation included administration of Resident 10's zolpidem on 07/22/2024 and 07/23/2024, as prescribed. Resident 10's record, as provided, did not include supporting documentation of Caregiver R administering Resident 10's sleeping medication to Resident 10 on 07/23/2024, nor any other date in July 2024. The provider did not ensure an investigation addressed 2 unaccounted for doses of Resident 10's zolpidem and the lack of

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Caregiver R's documentation of allegedly administering an alleged "missed" dose of a sleeping pill to Resident 10, as claimed by Caregiver R.

The staff's use of Resident 9's lorazepam on 07/23/2024 was discussed with House Manager B. Additionally, in controlled substance count logs maintained by the provider for Resident 9's lorazepam use, a deduction of 18 total tablets in July and August 2024 made by House Manager B, did not correlate with any sort of evidence that those tablets were administered to Resident 9. Despite House Manager B demonstrating awareness of these discrepancies, an investigation into the unaccounted-for lorazepam tablets was not conducted.

This requirement is being cited for the second time. See Statement of Deficiency (SOD) 54DT11, issued 03/24/2023.

The findings include:

On 08/01/2024, the department received allegations including resident medications not being administered by caregivers as prescribed.

Example 1: Resident 10's zolpidem medication

On 08/29/2024 at 8:05 A.M., Surveyor conducted an entrance interview with House Manager B. House Manager B told Surveyor s/he had recently completed administrator's training and would be involved in any investigations related to allegations regarding caregiver misconduct including misappropriation of resident medication. House Manager B told Surveyor there had been no allegations of and/or investigations conducted of caregiver misconduct since June 2024,

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N 158	Continued From page 3 including misappropriation of resident medication. On 08/29/2024 at 12:15 P.M., House Manager B told Surveyor Resident 10 died at the facility on 08/14/2024 and had been receiving hospice services. House Manager B provided Surveyor with Resident 10's individual service plan (ISP), not signed and not dated, Resident 1's medication administration record (MARs), and Resident 1's caregiver observation notes. Resident 10's diagnoses included cognitive impairment, insomnia, agitation, and major depressive disorder. On 08/29/2024 at 3:41 P.M., House Manager B told Surveyor Resident 10's record was disassembled after Resident 10's death and s/he did not have access to Resident 10's signed ISPs at the facility. House Manager B told Surveyor s/he would forward Resident 10's signed ISPs from March 2024 through Resident 1's death in August 2024 to Surveyor on 08/30/2024. Surveyor did not receive any ISPs for Resident 10 from any staff member at the facility, including House Manager B. Resident 10's ISP, not signed and not dated, included, "Medications administered by staff." On 08/29/2024 at 6:09 P.M., Surveyors conducted an interview with Caregiver D. Caregiver D told Surveyors Caregiver R, who worked during the night shift/usual sleeping hours between 11:00 P.M. and 7:00 A.M., "aggressively approached" Caregiver D in July 2024 about "making sure" Caregiver D was administering Resident 10's sleeping pill, zolpidem [a sedative/hypnotic sleep medication], at bedtime during the evening/3:00 P.M. to 11:00 P.M. shift. Caregiver D said s/he believed Caregiver R was administering an extra zolpidem to Resident 10 and/or administering "as needed" psychotropic medications, such as lorazepam, prescribed to	N 158		

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other residents after Caregiver R would arrive at the facility to work the night shift so s/he could sleep during the night. Caregiver D said s/he confronted Caregiver R about Resident 10's bedtime zolpidem dose was not ordered as an "as needed" medication and Caregiver R should not administer a second, extra dose of zolpidem to Resident 10 during the night shift. Caregiver D said Caregiver R became very upset, intimidating, and accused Caregiver D of not administering Resident 10's bedtime dose of zolpidem, as prescribed. Caregiver R said Resident 10 would not sleep during the night shift, was annoying, and would go into other resident rooms.
Caregiver D told Surveyors s/he worked the evening/3:00 P.M. to 11:00 P.M. shift on 07/23/2024 and noticed Resident 10's bedtime zolpidem dose was already popped out of the unit dose packaging card with the accompanying number/date of "23." Caregiver D said s/he also noticed at the same time Resident 10's bedtime zolpidem dose was already popped out of the unit dose packaging card with the accompanying number/date of "31." Caregiver D told Surveyors s/he took pictures of Resident 10's zolpidem unit dose packaging card and sent them with texts to report the situation to House Manager B.
Caregiver D offered to show Surveyor the texts between Caregiver D and House Manager B. The following, successive texts were reviewed with Caregiver D, with his/her permission, from Caregiver D's phone between House Manager B and Caregiver D, including: "Tue [Tuesday], Jul [July] 23 at 7:07 P.M. (Response) Who is tht [that]. [Resident 9]? (Sent) So this is [Resident 10]. Can [Caregiver D] call [House Manager B] [Caregiver D] have something very important to tell you. [Caregiver R] is [sic] been giving [him/her] extra sleeping pill in t [sic] in the middle of the night because [Caregiver R] says [Resident

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10] gets very annoying. Doesn't [sic] sleep at night and go [sic] to everybody's room. [Caregiver R] told [Caregiver D] that [sic] last night that [s/he] wasn't gonna [sic] put up with [Resident 10] and that [Caregiver R] been given [sic] [him/her] the sleeping pill and [Caregiver D] said no [Caregiver R] cannot give it to [Resident 10]. [Resident 10] got it at 8 o'clock and [Caregiver R] claimed that [Caregiver D] don't [sic] give it to [Resident 10] that's [sic] [Resident 10] doesn't [sic] sleep at night." A photo within Caregiver B's text string with House Manager B included Resident 10's-unit dose packaging card including a pharmacy label including Resident 10's name and "Zolpidem ER [extended release] 6.25 mg [milligram] tab [tablet], take 1 tablet by mouth every night at bedtime for insomnia." This photo included Resident 10's bedtime zolpidem dose was removed from the unit dose packaging card with the accompanying number/date of "23" with the protective seal broken and Resident 10's bedtime zolpidem dose removed from the unit dose packaging card with the accompanying number/date of "31" with the protective seal broken. The next text sent from Caregiver D to House Manager B included, "So look at these [sic] packet the PO [by mouth medication] for tonight is not even there and the one for the 31st is gone too." The following texts within the same successive string were reviewed with Caregiver D between House Manager B and Caregiver D on 07/23/2024, including: "This is. [sic] [Resident 10] I [Caregiver D] give [sic] [him/her] the one for 24 [sic; 07/24/2024]." Another photo within Caregiver B's text string with House Manager B included Resident 10's-unit dose packaging card including a pharmacy label including Resident 10's name and "Zolpidem ER [extended release] 6.25 mg [milligram] tab [tablet], take 1 tablet by mouth every night at bedtime for insomnia." This

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photo included Resident 10's bedtime zolpidem dose was removed from the unit dose packaging card with the accompanying number/date of "24" with the protective seal broken. Caregiver D told Surveyor s/he removed Resident 10's zolpidem dose originally packaged for 07/24/2024 and administered it to Resident 10 on the evening of 07/23/2024, since Resident 10's dose was already removed. Photos 6, 7, 8, 9, 10, 11, 12, and 13.

Surveyor reviewed Resident 10's July 2024 MAR, as received by House Manager B. Resident 10's July 2024 MAR included Caregiver D's documented administration of Resident 10's zolpidem, as prescribed, on 07/22/2024 at 7:56 P.M. and on 07/23/2024 at 9:21 P.M., both doses documented as being administered prior to the start of the night shift. Surveyor reviewed the facility's July 2024 schedule, provided by House Manager B on 08/29/2024, included Caregiver R was scheduled to work 8 hours between 07/22/2024 at 11:00 P.M. and 07/23/2024 at 7:00 A.M. Resident 10's July 2024 MAR and Resident 10's observation notes, as provided by House Manager B on 08/29/2024, did not include documentation of Resident 10's 07/23/2024 zolpidem dose being removed and administered prior to prescribed administration of that dose, and why Resident 10's 07/31/2024 zolpidem dose was removed prior to the prescribed administration of that dose. Resident 10's observation notes included a note dated 07/22/2024 at 6:30 A.M. by Caregiver R. Caregiver R's documentation included, "[Resident 10] was up all night, very combative in and out of people [sic] rooms all night. Refuse [sic] to go to [his/her] room and when trying to get [him/her] out of residents [sic] rooms was very argumentative and was trying to fight [Caregiver R] to [sic]. Did not sleep at all, up all night."

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N 158	Continued From page 7 Caregiver D told Surveyor s/he reported these concerns verbally and through texts with House Manager B because s/he was concerned for Resident 10's well-being. Caregiver D told Surveyor Resident 10 began to sleep more during the day during July 2024 and would not want to wake up for breakfast and lunch. Caregiver D said Resident 10 really began to decline because s/he was sleeping more during the day and eating less. Caregiver D told Surveyor House Manager B took Caregiver R off of medication pass but Caregiver R was allowed to continue to work at the facility. On 08/29/2024 at 8:18 P.M., Surveyors conducted an exit interview with House Manager B. Surveyor asked House Manager B if s/he recalled after the entrance interview earlier on this day receiving any allegations of caregiver misconduct in June 2024, July 2024, and/or August 2024. House Manager B said, "No." Surveyor asked House Manager B if s/he had received any allegations of Caregiver R misappropriating medications from Resident 10 in July 2024 and whether or not Caregiver R had been removed from performing resident medication administration at the facility at approximately the same time. House Manager B told Surveyor Caregiver D had sent him/her photos of medications and had documented allegations regarding Caregiver R and resident medications. House Manager B told Surveyor it was a "he said, she said" situation. House Manager B said Caregiver D complained caregivers, including Caregiver R, were lazy and would be on their phones while at work. House Manager B said Caregiver R complained s/he did not like working night shifts because the residents were restless. House Manager B said s/he did take Caregiver R "off of medication pass" duties.	N 158		

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Surveyor requested to be sent any and all of the facility's documented allegations and investigations regarding Caregiver R and resident medications, including those of Resident 10, by noon on 08/30/2024.

On 08/30/2024 at 11:47 A.M., Surveyors received an email from Administrator M including, "Here is the information you [Surveyors] requested from us [the facility]." The email included an attached typed, Word document. The document included, "On Tuesday 23rd. (July 23rd [Caregiver D] contacted me to let me know of [his/her] concerns with noc [night] shift [Caregiver R]). [Caregiver D] stating [Caregiver R] has been giving extra sleeping pills in the middle of the night because [s/he] gets very annoyed at night with the residents being [sic]. [Caregiver D] stated that [Caregiver R] said [s/he] was going to give [him/her] a sleeping pill so [s/he] can sleep and [Caregiver D] told [him/her] no because they get them at the bedtime med [medication] pass. [Caregiver D] stated that [Caregiver R] told [him/her] that [s/he] doesn't [sic] give 8 P.M. sleeping pills and that's [sic] why [s/he] stays awake at night. [Caregiver D] stated that [s/he] does give [him/her] meds [medications] every night." The documentation included, "On Wednesday July 24th [Caregiver R] stated when questioned that, [s/he] noticed resident was restless so [s/he] decided to look in med [medication] cart for anything [s/he] could take to relax [him/her]. [S/he] looked at [his/her] pm [evening] meds and noticed that a sleeping pill was not being passed at night, so [s/he] popped it out and passed it to [him/her]. When [Caregiver R] came in to work next s/he confronted [Caregiver D] about purposely not giving [him/her] this medication to make [him/her] nights hard. [Caregiver R] states [Caregiver D] is purposely

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trying to get [him/her] out of the building. Conclusion: [Caregiver R] passed a med [medication] that [s/he] noticed it had not been administered as scheduled, so [s/he] passed them late. No proof of misappropriation of medication." This received documentation did not specifically identify the correct year nor the resident in which the allegations were regarding. This received documentation, as requested regarding Caregiver R and Resident 10, did not include documentation of a review by the facility of Resident 10's record to come to an informed and/or accurate conclusion, including Caregiver D's documentation of administering sleep medication to Resident 10 on 07/22/2024 and 07/23/2024, as prescribed, and the lack of Caregiver R's documentation of allegedly administering an alleged "missed" dose of a sleeping pill.

Example 2: Resident 9 lorazepam medication

On 08/29/2024 at 8:05 A.M., Surveyor conducted an entrance interview with House Manager B. House Manager B told Surveyor s/he had recently completed administrator's training and would be involved in any investigations related to allegations regarding caregiver misconduct including misappropriation of resident medication. House Manager B told Surveyor there had been no allegations of and/or investigations conducted of caregiver misconduct, including misappropriation of resident medication, since June 2024.

On 08/29/2024, Surveyor reviewed Resident 9's record. Resident 9 was admitted to the provider on 03/26/2020 with diagnoses including unspecified chest pain and hypertensive heart

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disease with heart failure. Resident 9 was documented as having an activated power of attorney (POA) for healthcare. Resident 9 was documented as receiving hospice services. Resident 9's prescriptions included lorazepam 0.5 mg tablets, started on 05/31/2024, with instructions to, "Take 1 tablet by mouth every 1 hour as needed for anxiety, agitation, restlessness."

On 08/29/2024, Surveyor reviewed Resident 9's medication administration records (MARs) from 06/01/2024 - 08/29/2024 and observed the following 12 total administrations of Resident 9's PRN lorazepam:

- June 2024: 2 administrations of his/her lorazepam (on 06/12/2024 at 8:32 p.m. and 06/21/2024 at 6:01 p.m.)
- July 2024: 3 administrations of his/her lorazepam (on 07/15/2024 at 5:41 p.m., 07/27/2024 at 2:29 a.m., and 07/28/2024 at 12:44 a.m.)
- August 2024: 6 administrations of his/her lorazepam (on 08/08/2024 at 6:03 p.m., 08/13/2024 at 2:18 p.m., 08/23/2024 at 8:04 p.m., 08/25/2024 at 3:32 p.m., 08/28/2024 at 12:22 a.m., and 08/28/2024 at 3:30 a.m.).

On 08/29/2024 at 6:09 P.M., Surveyors conducted an interview with Caregiver D. Caregiver D told Surveyors s/he believed Caregiver R was administering an extra dose of zolpidem to Resident 10 and/or administering "as needed" psychotropic medications, such as lorazepam, prescribed to other residents, including Resident 9, after Caregiver R would arrive at the facility to work the night shift so s/he could sleep during the night. Caregiver D said s/he believed Caregiver R was taking "as

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needed" lorazepam tablets from other resident unit dose packaging cards, including Resident 9's. Caregiver D said it was possible Caregiver R was taking from each resident's prescribed "as needed" lorazepam card, including Resident 9's, on a rotation so it was not as noticeable.
Caregiver D said Resident 9 did not really need to take lorazepam. Caregiver D said Resident 9's "as needed" lorazepam was ordered by Resident 9's hospice agency and Resident 9 was not that "behavioral" and was not at the end-of-life stage. Caregiver D said Resident 9 rarely needed to be administered lorazepam before a shower to decrease his/her anxiety surrounding the bathing process.
Caregiver D told Surveyors s/he worked the evening/3:00 P.M. to 11:00 P.M. shift on 07/23/2024 and took a picture of Resident 9's lorazepam unit dose packaging card and sent it via text to House Manager B. Caregiver D offered to show Surveyor the texts between Caregiver D and House Manager B. With permission from Caregiver D, the following text was reviewed between House Manager B and Caregiver D from Caregiver D's phone, including: "Tue [Tuesday], Jul [July] 23 at 7:07 P.M. A photo of Resident 9's lorazepam unit dose packaging card included a pharmacy label including Resident 9's name, the dispensed date "05/31/2024" and "Lorazepam 0.5 mg [milligram] tab [tablet], take 1 tablet by mouth every 1 hour as needed for anxiety, agitation, restlessness." Caregiver D said s/he sent this photo to House Manager B because too many of Resident 9's lorazepam's tablets were popped out, s/he would not have needed to use all of those tablets. Photos 14 and 15.

On 08/29/2024, at approximately 6:50 p.m., Surveyor, along with House Manager B and

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(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 158	Continued From page 12 Caregiver K, observed Resident 9's medications located within the controlled substances locked box within the medication cart. Surveyor observed 1 card of PRN lorazepam for Resident 9. The pharmacy label on the card indicated that the card, which initially contained 30 tablets, was dispensed on 08/27/2024. Surveyor observed that 3 tablets were punched out from the card. House Manager B confirmed that it was the provider's standard practice to maintain a controlled substance count log for residents prescribed lorazepam, including Resident 9, and that staff were expected to conduct counts every shift upon shift change. Surveyor asked what the count for Resident 9's tablets were in the provider's-controlled substance count log. House Manager B pulled up the log from the facility laptop, located on top of the medication cart. Under "Quantity On Hand", the count was shown as "-1." House Manager B reported s/he didn't know how or why the lorazepam count showed as having a negative number value. Surveyor observed that the on-hand lorazepam quantity of "-1" documented from the provider's log did not coincide with the on-hand quantity of 27 tablets observed in his/her card. While interviewing House Manager B at the medication cart regarding Resident 9's lorazepam, Surveyor observed House Manager B type the lorazepam count that was just completed by Surveyor and House Manager B as a quantity of 28 in order to make a new total of 27, the number of tablets that were just counted. Surveyor asked House Manager B if this still would be an issue since s/he did not have any way to account for how the tablets had been deducted prior to the survey. House Manager B nodded but said s/he still wanted to enter the current count because s/he didn't want it to be off. Surveyor then requested for House Manager B to provide historic	N 158		

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lorazepam counts for Resident 9 from 06/01/2024 - 08/29/2024.

On 08/30/2024, Surveyor reviewed the lorazepam count log for Resident 9 from 06/01/2024 - 08/29/2024, provided by House Manager B. Surveyor also cross-referenced the log with Resident 9's MARs and observation notes for the same date range. The log showed a starting quantity of 30 tablets on 06/01/2024 and the following deductions:

- June 2024: Deduction of 2 tablets (correlating with the same dates/times of administration of his/her MAR)
- July 2024: Deduction of 6 tablets (2 tablets on 07/09/2024 at 2:56 p.m., 1 tablet on 07/10/2024 at 2:44 p.m., 1 tablet on 07/15/2024 at 5:41 p.m., 1 tablet on 07/27/2024 at 2:29 a.m., and 1 tablet on 07/28/2024 at 12:44 a.m.).

Surveyor observed that the 3 total tablets deducted on 07/09/2024 and 07/10/2024, above, did not correlate with any administrations of Resident 9's lorazepam as documented in his/her MAR or observation notes on or around those dates. Surveyor observed that the deductions of those 3 tablets were made by House Manager B. No notes in the log were entered to account for this discrepancy.

- August 2024, from 08/01/2024 through 08/27/2024 when the new card was dispensed: Deduction of 20 tablets (1 tablet on 08/08/2024 at 6:03 p.m., 15 tablets on 08/09/2024 at 2:47 p.m., 1 tablet on 08/13/2024 at 2:18 p.m., 1 tablet on 08/20/2024 at 12:29 p.m., 1 tablet on 08/23/2024 at 8:04 p.m., and 1 tablet on 08/25/2024 at 3:32 p.m.)

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Surveyor observed that the 16 total tablets deducted on 08/09/2024 and 08/20/2024, above, did not correlate with any administrations of Resident 9's lorazepam as documented in his/her MAR or observation notes on or around those dates. Surveyor observed that the deductions of those 16 tablets were made by House Manager B. No notes in the log were entered to account for this discrepancy.

On 08/30/2024, at approximately 12:40 p.m., Surveyor interviewed Director of Operations HH from the pharmacy that dispensed Resident 9's medications. Director of Operations HH confirmed that the order for Resident 9's PRN lorazepam first was received on 05/31/2024. Director of Operations HH reported that only 2 lorazepam cards had been dispensed since the order began - 1 card of 30 tablets on 06/03/2024 and 1 card of 30 tablets on 08/28/2024.

On 08/29/2024 at 8:18 P.M., Surveyors conducted an exit interview with House Manager B. Surveyor asked House Manager B if s/he recalled after the entrance interview earlier on this day receiving any allegations of caregiver misconduct in June 2024, July 2024, and/or August 2024. House Manager B said, "No." Surveyor asked House Manager B if s/he had received any allegations of Caregiver R misappropriating medications from Resident 9 in July 2024 and whether Caregiver R had been removed from performing resident medication administration at the facility at approximately the same time as the allegations. House Manager B told Surveyor Caregiver D had sent him/her photos of medications. House Manager B said there was nothing captured by the camera located in the facility's medication room regarding Resident 9's lorazepam medications, "no one

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touched lorazepam for [Resident 9]." House Manager B told Surveyor it was a "he said, she said" situation. House Manager B said Caregiver D complained caregivers, including Caregiver R, were lazy and would be on their phones while at work. House Manager B said Caregiver R complained about not liking working night shifts because the residents were restless. House Manager B said s/he did take Caregiver R "off of medication pass" duties.
Surveyor requested to be sent by noon on 08/30/2024 any and all of the facility's documented allegations and investigations regarding Caregiver R and resident medications, including those of Resident 9.

On 08/30/2024 at 11:47 A.M., Surveyors received an email from Administrator M including, "Here is the information you [Surveyors] requested from us [the facility]." The email included two attached typed, Word documents. Neither of the documents referenced anything about Resident 9 or Resident 9's lorazepam.

Nothing in the information provided detailed any kind of follow up investigation that was done regarding Resident 9's lorazepam administration discrepancies, including the lorazepam discrepancy in his/her card supply brought up to House Manager B by Caregiver D or the edits to Resident 9's count supply made by House Manager B - the deduction of 19 total lorazepam tablets not otherwise accounted for by him/her.

Summary: The provider did not ensure allegations regarding misappropriation of resident medication, including medications belonging to Resident 10 and Resident 9, were investigated, and documented.

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N 158	Continued From page 16 Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws N0408 DHS 83.37(1)(i) PRN Psychotropic Medication	N 158		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 8's activated power of attorney for healthcare (POA) was notified when Resident 8 had an unwitnessed fall out of bed on 12/22/2023 that resulted in him/her sustaining a 2 cm laceration near his/her left eye and requiring 5 sutures to be placed in the emergency department. The findings include: On 08/29/2024, Surveyor conducted a complaint investigation into concerns of residents' legal representatives not being notified upon injuries sustained by residents. On 08/29/2024, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider	N 169		

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on 11/28/2023 with diagnoses including dementia, congestive heart failure, and atrial fibrillation. Resident 8 resided with the provider until s/he passed away on 07/17/2024. Resident 8 was documented on his/her face sheet as having an activated POA for healthcare. Surveyor reviewed all incident reports in Resident 8's record. In reviewing the reports, Surveyor observed 2 incident reports that detailed the same fall experienced by Resident 8 on 12/22/2023 sometime between 10:30 p.m. - 11:02 p.m. Both reports documented that Resident 8 sustained an unwitnessed fall by rolling off his/her bed, and that Resident 8 sustained a facial skin tear/laceration as well as bruising near his/her left eye. One of the reports documented that Resident 8 was taken via emergency medical services (EMS) to the emergency department. Under the "Response to Incident" section of the report, a prompted question asked, "Family or Representative Notified?" In both reports, staff documented "No" to this question.

On 09/04/2024, at approximately 4:30 p.m., Surveyor interviewed Family Member W. Family Member W confirmed that s/he was not notified by anyone about Resident 8's fall with subsequent facial laceration with suture placement. Family Member W reported s/he found out him/herself when s/he visited Resident 8 the morning after the incident and saw Resident 8's bruising and laceration.

On 09/04/2024, Surveyor reviewed text message screenshots between Former Administrator A and Family Member W, who was Resident 8's activated POA and provided the screenshots. In the messages, Surveyor observed the following:

- Text from Family Member W to Former

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N 169	Continued From page 18 Administrator A, sent 12/23/2024 at 8:57 a.m. (the morning after Resident 8 fell): "Sorry to bother you [Former Administrator A], but you need to call me immediately. I just came to visit [Resident 8] and apparently [s/he] fell out of bed yesterday and has stitches in [his/her] eyes and nobody contacted me ..." - Text message response from Former Administrator A to Family Member W, sent 12/23/2024 (time not specified): "[Oh my god (OMG)], I wasn't even contacted about [him/her] falling. I sincerely apologize for nobody contacting you. I'll reach out to the director and see what happened ..." Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws	N 169		
N 189	83.13(3)(b) Post house rules, resident rights, grievances The CBRF shall post all of the following: House rules, resident rights and grievance procedures as required under s. DHS 83.32(2) (b). This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that the grievance procedure was posted. This requirement is being cited for the second time. See Statement of Deficiency (SOD) 54DT11, issued 03/24/2023. The findings include:	N 189		

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N 189	Continued From page 19 On 08/29/2024, at approximately 7:45 p.m., Surveyor toured the environment. Surveyor observed several documented posted near the provider's front entrances as well as documents posted in a display case near the provider's dining area. Surveyor did not observe the provider's grievance procedure posted anywhere in the facility. At approximately 8:30 a.m., Surveyor interviewed Resident 12. Resident 12 reported that s/he wanted to know the process for making a complaint when s/he had concerns about the facility's operation. At approximately 8:15 p.m., Surveyor toured the environment again. Surveyor did not observe a grievance procedure posted anywhere in the facility. At approximately 8:18 p.m., Surveyor interviewed House Manager B. House Manager B acknowledged Surveyor's concern that the grievance procedure was not posted and reported that if it had been posted it would have been in the display case near the dining area. On 08/30/2024, at 11:47 a.m., Administrator M e-mailed a photograph to Surveyors of a grievance procedure posted in the provider's display case. At approximately 12:34 p.m., House Manager B e-mailed Surveyor, confirming s/he had just posted the provider's grievance procedure that morning. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws	N 189		

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N 196	Continued From page 20	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 interview and record review, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. This requirement is being cited for the fifth time. See Statement of Deficiency (SOD) KNVD11, issued 11/16/2021, SOD FT8K11, issued 03/17/2023, SOD 54DT11, issued 03/24/2023, and SOD FT8K12, issued 06/16/2023. The findings include: On 08/29/2024, with information gathered through 10/02/2024, two Surveyors conducted a standard licensing survey, two complaint investigations, and a verification visit for SOD OCCY11. 32 citations of noncompliance were identified, including 18 repeat citations of noncompliance. Two of 2 complaints were substantiated. N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse And Neglect This requirement is being cited for the second time. See SOD 54DT11, issued 03/24/2023. N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes N0189 DHS 83.19(3)(b) Post House Rules,	N 196		

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N 196	Continued From page 21 Resident Rights, Grievances This requirement is being cited for the second time. See SOD 54DT11, issued 03/24/2023. N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws This requirement is being cited for the fifth time. See SOD KNVD11, issued 11/16/2021, SOD FT8K11, issued 03/17/2023, SOD 54DT11, issued 03/24/2023, and SOD FT8K12, issued 06/16/2023. N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease This requirement is being cited for the second time. See SOD UDWF11, issued 02/19/2021. N0230 DHS 83.19 Orientation N0239 DHS 83.20(2)(a)-(d) Department Approved Training Courses N0243 DHS 83.21(1)-(3) All Employee Training This requirement is being cited for the second time. See SOD UDWF11, issued 02/19/2021. N0247 DHS 83.22(1)-(4) Task Specific Training This requirement is being cited for the third time. See SOD UDWF11, issued 02/19/2021, and SOD 54DT11, issued 03/24/2023. N0302 DHS 83.28(4)(a) Resident Health Screening And Documentation This requirement is being cited for the second time. See SOD UDWF11, issued 02/19/2021. N0352 DHS 83.32(3)(h) Residents Of Residents: Receive Medications This requirement is being cited for the fifth time. See SOD UDWF11, issued 02/19/2021, SOD	N 196		

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N 196	Continued From page 22 UDWF12, issued 06/17/2021, SOD 54DT11, issued 03/24/2023, and SOD FT8K12, issued 06/16/2023. N0362 DHS 83.33(1)(d) Grievance Procedure: Written Summary N0836 DHS 83.35(3)(a) Comprehensive Individual Service Plan This requirement is being cited for the fifth time. See SOD UDWF11, issued 02/19/2021, SOD UDWF12, issued 06/17/2021, SOD 54DT11, issued 03/24/2023, and FT8K12, issued 06/16/2023. N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes This requirement is being cited for the sixth time. See SOD UDWF11, issued 02/19/2021, SOD UDWF12, issued 06/17/2021, SOD 54DT11, issued 03/24/2023, SOD FT8K12, issued 06/16/2023 and SOD OCCY11, issued 06/17/2024. N0397 DHS 83.36(1)(b) Qualified Staff In Charge, On Duty, And Awake This requirement is being cited for the third time. See SOD UDWF12, issued 06/17/2021, and FT8K11, issued 06/16/2023. N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule N0407 DHS 83.37(1)(h) Scheduled Psychotropic Medications This requirement is being cited for the second time. See SOD UDWF11, issued 02/19/2021.	N 196		

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N 196	Continued From page 23 N0408 DHS 83.37(1)(i) PRN Psychotropic Medication N0409 DHS 83.37(1)(j) Proof-Of-Use Record N0415 DHS 83.37(2)(d) Documentation Of Medication Administration N0425 DHS 83.38(1)(a) Personal Care This requirement is being cited for the second time. See SOD OCCY11, issued on 06/17/2024. N0426 DHS 83.38(1)(b) Supervision N0431 DHS 83.38(1)(g) Health Monitoring This requirement is being cited for the second time. See SOD 54DT11, issued 03/24/2023. N0432 DHS 83.38(1)(h) Medication Administration N0452 DHS 83.41(3)(b) Food Safety This requirement is being cited for the third time. See SOD FT8K11, issued 03/17/2023, and SOD OCCY11, issued 06/17/2024. N0454 DHS 83.42(1) Resident Record Maintained N0481 DHS 83.43(1) Environment Safe, Clean, and Comfortable This requirement is being cited for the fourth time. See Statement of Deficiency (SOD) 54DT11, issued 03/24/2023,, SOD FT8K12, issued 06/16/2023, and SOD OCCY11, issued 06/17/2024. N0526 DHS 83.47(2)(e) Other Evacuation Drills	N 196		

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N 196	Continued From page 24	N 196		

N0612 DHS 83.55(3) Bath And Toilet Areas: Hand Drying
This requirement is being cited for the second time. See SOD OCCY11, issued 06/17/2024.

N0637 DHS 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways

N0640 DHS 83.59(2)(b) Solid Core Wood Doors Or Equivalent
This requirement is being cited for the second time. See SOD FT8K13, issued 08/23/2023.

On 08/29/2024 at 4:02 P.M., Surveyor conducted an interview with Administrator M. Administrator M told Surveyor s/he had been the administrator of the facility for approximately 2 weeks since Former Administrator A had terminated employment with the facility. Administrator M told Surveyor s/he was aware of the facility's last issued statement of deficiency and recent noncompliance history. Administrator M told Surveyor s/he needed to leave the facility for personal reasons after this interview. Surveyor informed Administrator M the Surveyors would conduct an exit interview with House Manager B in Administrator M's absence before leaving the facility. Administrator M told Surveyor, "[House Manager B] will let me know."

On 08/29/2024, at approximately 8:18 p.m., Surveyors conducted an interview with House Manager B, including a discussion regarding the concerns with noncompliance identified during this visit including concerns of identified repeat noncompliance. House Manager B said the facility had experienced several recent changes, including Former Administrator A leaving employment and Administrator M starting within the last few weeks, a recent change of Former

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N 196	Continued From page 25 Facility Nurse FF leaving employment and Facility Nurse N starting with the facility in June 2024, and ongoing issues with maintaining caregivers on staff.	N 196		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that documentation was obtained from a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse indicating that 2 of 3 employees were screened for clinically apparent communicable disease including tuberculosis. This requirement is being cited for the second time. See Statement of Deficiency (SOD) UDWF11, issued 02/19/2021. The findings include:	N 220		

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N 220	Continued From page 26 On 08/29/2024, Surveyor reviewed employee communicable disease screens to verify compliance with communicable disease screen requirements. Surveyor requested employee communicable disease screens for Caregivers K, O, and P from House Manager B. The record for Caregiver K, hired 02/20/2024, consisted of a tuberculosis-specific screen that was signed by him/her and a tuberculosis skin test section that was signed by Former Facility Licensed Practical Nurse (LPN) S. There was no evidence that anyone other than Former Facility LPN S screened Caregiver K for communicable diseases. The record for Caregiver P, hired 04/09/2024, consisted of a tuberculosis-specific screen that was signed by him/her and a tuberculosis skin test section that was signed by Former Facility LPN S. There was no evidence that anyone other than Former Facility LPN S screened Caregiver P for communicable diseases. At approximately 8:18 p.m., Surveyors interviewed House Manager B. House Manager B confirmed that Former Facility LPN S was the provider's former LPN. House Manager B reported s/he was unaware that employee communicable disease screens had to be conducted by a medical provider or licensed registered nurse. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws	N 220		
N 230	83.19 Orientation	N 230		

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N 230	Continued From page 27 Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 3 of 3 employees reviewed obtained orientation training that included all the required topics before performing any job duties. Caregivers K, O, and P were not trained in preventing and reporting resident abuse, neglect, and misappropriation of resident property; information regarding the assessed needs and individual services for each resident whom s/he was responsible, emergency and disaster plan and evacuation procedures, or recognizing and responding to resident changes of condition. The findings include: On 08/29/2024, Surveyor conducted a review of 3 employees to verify compliance with orientation training requirements. Surveyor requested training records from House Manager B for Caregivers K, O, and P.	N 230		

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N 230	Continued From page 28 Example 1 - Caregiver K The record for Caregiver K, hired 02/20/2024, did not contain evidence of training in preventing and reporting resident abuse, neglect, and misappropriation of resident property; information regarding the assessed needs and individual services for each resident whom s/he was responsible, emergency and disaster plan and evacuation procedures, or recognizing and responding to resident changes of condition. Example 2 - Caregiver O The record for Caregiver O, hired 07/16/2024, did not contain evidence of training in preventing and reporting resident abuse, neglect, and misappropriation of resident property; information regarding the assessed needs and individual services for each resident whom s/he was responsible, emergency and disaster plan and evacuation procedures, or recognizing and responding to resident changes of condition. Example 3 - Caregiver P The record for Caregiver P, hired 04/09/2024, did not contain evidence of training in preventing and reporting resident abuse, neglect, and misappropriation of resident property; information regarding the assessed needs and individual services for each resident whom s/he was responsible, emergency and disaster plan and evacuation procedures, or recognizing and responding to resident changes of condition. INTERVIEW: On 08/29/2024, at approximately 5:16 p.m.,	N 230		

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N 230	Continued From page 29 Surveyor interviewed House Manager B. House Manager B confirmed s/he did not have any other training records for Caregivers K, O, and P, but reported there may have been some additional trainings via in-service meetings the provider hosted. Surveyor then requested all in-service records for 2024. In the subsequent in-service records House Manager B provided and reviewed by Surveyor that day, there was no evidence that Caregivers K, O, and P were trained in the above orientation topics. House Manager B confirmed s/he did not have any other in-service records. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses N0243 DHS 83.21(1)-(3) All Employee Training N0247 DHS 83.22(1)-(4) Task Specific Training	N 230		
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 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	N 239		

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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 2 of 3 employees reviewed obtained all department approved training in the timeframes required.

Caregiver K completed fire safety training approximately 2.5 weeks after it was due and Caregiver P completed first aid and choking training approximately 1 week after it was due.

The findings include:

On 08/29/2024, Surveyor conducted a review of 3 employees to verify compliance with department-approved training requirements. Surveyor requested training records from House Manager B for Caregivers K, O, and P.

Fire Safety

The record for Caregiver K, hired 02/20/2024, contained evidence that s/he was trained in fire safety on 06/05/2024, approximately 2.5 weeks after the 90-day requirement.

First Aid and Choking

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N 239	Continued From page 31 The record for Caregiver P, hired 04/09/2024, contained evidence that s/he was trained in first aid and choking on 07/17/2024, approximately 1 week after the 90-day requirement. INTERVIEW: On 08/29/2024, at approximately 5:16 p.m., Surveyor interviewed House Manager B. House Manager B acknowledged Surveyor's concerns regarding the trainings for Caregivers K and P being late and appeared to take notes but said nothing further. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws N0230 DHS 83.19 Orientation N0243 DHS 83.21(1)-(3) All Employee Training N0247 DHS 83.22(1)-(4) Task Specific Training	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.	N 243		

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N 243	Continued From page 32 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 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. Caregivers K did not have training in resident rights within 90 days after starting employment. Caregivers K, O, and P did not have training in recognizing, preventing, managing, and	N 243		

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responding to challenging behaviors within 90 days after starting employment.

Caregivers K, O, and P did not have training in required client groups within 90 days after starting employment.

This requirement is being cited for the second time. See Statement of Deficiency (SOD) UDWF11, issued 02/19/2021.

The findings include:

On 08/29/2024, Surveyor conducted a review of 3 employees to verify compliance with all employee training requirements. Surveyor requested training records from House Manager B for Caregivers K, O, and P.

Resident Rights

The record for Caregiver K, hired 02/20/2024, contained evidence that s/he was trained in resident rights on 07/18/2024, approximately 2 months after the 90-day requirement.

Recognizing, Preventing, Managing, and Responding to Challenging Behaviors

The record for Caregiver K, hired 02/20/2024, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training.

The record for Caregiver O, hired 07/16/2024, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training.

The record for Caregiver P, hired 04/09/2024, did

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not contain evidence of training or evidence of meeting an exemption for challenging behaviors training.

Client Group

The provider is licensed to provide care and services to residents within the client groups of emotionally disturbed/mental illness, physically disabled, irreversible dementia/Alzheimer's, and advanced aged.

The record for Caregiver K, hired 02/20/2024, did not contain evidence of training or evidence of meeting an exemption for client group training.

The record for Caregiver O, hired 07/16/2024, did not contain evidence of training or evidence of meeting an exemption for client group training.

The record for Caregiver P, hired 04/09/2024, did not contain evidence of training or evidence of meeting an exemption for client group training.

INTERVIEW:

On 08/29/2024, at approximately 5:16 p.m., Surveyor interviewed House Manager B. House Manager B confirmed s/he did not have any other training records for Caregivers K, O, and P, but reported there may have been some additional trainings via in-service meetings the provider hosted. Surveyor then requested all in-service records for 2024. In the subsequent in-service records House Manager B provided, reviewed by Surveyor that day, there was no evidence that Caregivers K, O, and P were trained in or met exemptions for the above missing topics, or that Caregiver K completed resident rights training within 90 days of his/her hire. House Manager B

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N 243	Continued From page 35 confirmed s/he did not have any other in-service records. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws N0230 DHS 83.19 Orientation N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses N0247 DHS 83.22(1)-(4) Task Specific Training	N 243		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and	N 247		

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foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring.
Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation.

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 task specific training as required.

Caregivers K, O, and P, who all had responsibilities for providing assistance with activities of daily living, did not have training in the provision of personal care prior to assuming these duties.

Caregiver K, who performed dietary duties, did not have training in dietary services within 90 days after assuming these job duties.

This requirement is being cited for the third time. See Statement of Deficiency (SOD) UDWF11, issued 02/19/2021, and SOD 54DT11, issued 03/24/2023.

The findings include:

On 08/29/2024, Surveyor conducted a review of 3 employees to verify compliance with task specific training requirements. Surveyor requested

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training records from House Manager B for Caregivers K, O, and P.

Provision of Personal Care

On 08/29/2024, Surveyor reviewed the staff schedule, which showed that Caregivers O and P were scheduled to work as caregivers during that day's first shift.

While Surveyors were on site from approximately 7:41 a.m. until approximately 9:30 p.m., both Caregivers O and P were engaged in resident care tasks during their shift. From approximately 3:00 p.m. until Surveyors left at approximately 9:30 p.m., Caregiver K was observed working second shift and conducting resident care tasks.

The record for Caregiver K, hired 02/20/2024, did not contain evidence of training or evidence of meeting an exemption for personal care training.

The record for Caregiver O, hired 07/16/2024, did not contain evidence of training or evidence of meeting an exemption for personal care training.

The record for Caregiver P, hired 04/09/2024, did not contain evidence of training or evidence of meeting an exemption for personal care training.

Dietary Training

On 08/29/2024, at approximately 4:25 p.m., Surveyor observed Caregivers D and K in the kitchen helping to prepare and plate dinner. Both confirmed that while the provider's community cook made all the food offsite, caregiving staff were typically responsible for re-heating it (if needed) once it was delivered, plating the food from communal dishes, and serving the food to

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residents.

The record for Caregiver K, hired 02/20/2024, contained evidence that s/he completed dietary training on 07/11/2024, approximately 2 months after the 90-day requirement.

INTERVIEW:

On 08/29/2024, at approximately 5:16 p.m., Surveyor interviewed House Manager B. House Manager B confirmed that Caregivers K, O, and P are responsible for providing personal cares and that caregiving staff, including Caregiver K, were responsible for dietary tasks. House Manager B confirmed s/he did not have any other training records for Caregivers K, O, and P, but reported there may have been some additional trainings via in-service meetings the provider hosted. Surveyor then requested all in-service records for 2024. In the subsequent in-service records House Manager B provided, reviewed by Surveyor that day, there was no evidence that Caregivers K, O, and P completed or met an exemption for personal cares training, or that Caregiver K completed dietary training within 90 days of assuming dietary duties. House Manager B confirmed s/he did not have any other in-service records.

Cross Reference:
N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws
N0230 DHS 83.19 Orientation
N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses
N0243 DHS 83.21(1)-(3) All Employee Training
N0425 DHS 83.38(1)(a) Personal Care

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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 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 that within 90 days before or 7 days after Resident 8's admission, a physician, physician assistant, clinical nurse practitioner, or a licensed registered nurse screened him/her for clinically apparent communicable disease, including tuberculosis. This requirement is being cited for the second time. See Statement of Deficiency (SOD) UDWF11, issued 02/19/2021. The findings include: On 08/29/2024, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider on 11/28/2023. Resident 8's communicable disease screen consisted of a document titled,	N 302		

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N 302	Continued From page 40 "[TUBERCULOSIS (TB)] TEST FORM" that contained questions specific to tuberculosis symptoms and previous tuberculosis testing and treatment, with a section at the bottom for his/her tuberculosis skin test result. The form was signed as reviewed by Former Facility Licensed Practical Nurse (LPN) S. There was no other screen in Resident 8's record. There was no evidence that anyone other than Former Facility LPN S screened Resident 8 for communicable diseases. At approximately 8:18 p.m., Surveyors interviewed House Manager B. House Manager B confirmed that Former Facility LPN S was the provider's former LPN. House Manager B reported s/he was unaware that resident communicable disease screens had to be conducted by a licensed registered nurse or medical provider. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws	N 302		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 2, Resident 5, Resident 11, and Resident 14	N 352		

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received all prescribed medications in the dosage and at intervals prescribed by a practitioner.

Resident 2 was not administered morning medications, as prescribed, on 08/29/2024 including Resident 2's Humalog insulin (an injectable, diabetic medication) and omeprazole (a gastroesophageal reflux disorder medication) before meals and Resident 2's ferrous sulfate (an iron supplement) and metformin (a diabetic medication) with meals. Resident 2's 08/29/2024 noon Humalog insulin dose, as prescribed, was not administered by Caregiver O.

Without a practitioner's order to crush Resident 5's medications, Caregiver O attempted to administer Resident 5's morning medications crushed on 08/29/2024. On 08/29/2024, Caregiver O attempted to administer Resident 5's levothyroxine (thyroid medication) dose at least one-half hour after Resident 5 had consumed breakfast instead of on an empty stomach, as prescribed.

Resident 11 was not administered medications, as prescribed, on 08/29/2024 including Resident 11's polyethylene glycol (a bowel medication), Deep Sea nasal spray (a saline solution to treat nasal issues), Lubriderm lotion (for dry skin), and Ensure (a nutritional supplement).

Resident 14 was not administered medications, as prescribed, on 08/29/2024 including Vitamin D, Spiriva (a respiratory medication) inhalations, fluconazole nasal spray, and the correct dose of pantoprazole (a gastroesophageal reflux disorder medication). Resident 14 was administered acetaminophen tablets, despite being previously discontinued. Based on observation of Resident 14's unused, prescribed Spiriva inhaler, Resident

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14 was not administered this inhaler, as prescribed, between 08/01/2024 and 08/29/2024, despite almost daily documentation of administration by caregivers.

This requirement is being cited for the fifth time. See Statement of Deficiency (SOD) UDWF11, issued 02/19/2021, UDWF12, issued 06/17/2021, SOD 54DT11, issued 03/24/2023, and SOD FT8K12, issued 06/16/2023.

The findings include:

On 08/01/2024, the department received allegations including resident medications not being administered by caregivers as prescribed.

On 08/29/2024 at 7:35 A.M., Caregiver O told Surveyors s/he was working alone as the only caregiver on duty at the facility and s/he had started his/her shift at 7:00 A.M. Caregiver O said s/he was waiting for the other caregiver to show up for work and no medications had been administered to the residents since Caregiver O arrived on duty. Caregiver O said the other caregiver was to be on duty at 7:00 A.M. and was supposed to be administering medications. Caregiver O told Surveyor s/he did not know the name of the caregiver scheduled to work with him/her from 7:00 A.M. until 3:00 P.M.

On 08/29/2024 at 8:48 A.M., Surveyor observed Caregiver P enter the facility from a car parked in the front parking lot. Caregiver P told Surveyor s/he just "came from home" and was scheduled to work until 3:00 P.M.

Example 1: Resident 2

On 08/29/2024 at 8:20 A.M., Caregiver O told

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Surveyor s/he took Resident 2 his/her breakfast to eat in Resident 2's room, as requested by Resident 2.

On 08/29/2024 at approximately 8:32 A.M., Surveyor observed Resident 2 seated at the edge of his/her bed eating cereal and milk from a bowl and 1 piece of toast. Resident 2 said s/he was almost finished eating all of the cereal s/he had been served and the piece of toast. Resident 2 told Surveyor s/he was not offered a piece of fruit, including a banana, with breakfast that morning.

On 08/29/2024 at 08:53 A.M., Caregiver O told Surveyor s/he would be administering resident medications instead of Caregiver P. Caregiver O did not provide Surveyor a reason for the change in plan for medication administration when asked. Caregiver O told Surveyor s/he was not sure if any residents have insulin ordered and stated, "I [Caregiver O] have to look." Caregiver O told Surveyor no insulin had been administered to any of the residents this morning.

On 08/29/2024 at 9:46 A.M., Surveyor observed Caregiver O prepare to administer Resident 2's oral, tablet medications and injectable insulin [diabetic medication] greater than one hour after Resident 2 completed breakfast. Caregiver O dispensed Resident 2's oral medications into a small medication cup, including an omeprazole (a gastroesophageal reflux disorder medication) 40 mg (milligram) capsule, a ferrous sulfate (an iron supplement) 325 mg tablet, and a metformin (a diabetic medication) 1000 mg tablet. Caregiver O locked the medication cart and shut the medication room door with the medication cup of Resident 2's oral medications in his/her hand. Surveyor asked if s/he had dispensed all of Resident 2's medications to be administered this

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morning, as prescribed. Caregiver O responded to Surveyor, "Yes." Surveyor asked if Resident 2 had blood glucose monitoring and/or insulin ordered to be administered in the morning. Caregiver O responded to Surveyor by opening the medication door, opening the medication cart, and removing a pen-syringe of Humalog. Surveyor observed Caregiver O did not remove a glucometer, a device to check Resident 2's blood glucose, from the medication cart. Caregiver O entered Resident 2's room and administered Resident 2's oral medications, as dispensed. Surveyor observed Caregiver O dial 6 units of Humalog insulin pen without first priming the syringe. Caregiver O appeared to administer the insulin to Resident 2's abdomen. Caregiver O said, "I [Caregiver O] am not sure if the insulin went in." Caregiver O wiped the injection site with a tissue. Resident 2 said s/he didn't really feel it, except his/her skin felt wet. Surveyor observed Caregiver O did not check Resident 2's blood glucose level. Caregiver O left Resident 2's room, returned to the medication cart, and documented administration of Resident 2's medications at 9:54 A.M.

On 08/29/2024 at 10:06 A.M., Surveyor conducted an interview with Resident 2. Resident 2 told Surveyor s/he did not have his/her blood glucose checked this morning. Resident 2 said his/her blood glucose was supposed to be monitored before s/he eats breakfast in the morning. Resident 2 told Surveyor the caregivers often ignore him/her when s/he asks them to administer insulin, as prescribed, before s/he is served and eats a meal. Resident 2 said the caregivers control administration of all of his/her medications. Resident 2 told Surveyor s/he was concerned about his/her blood sugar getting higher if it was not monitored consistently and

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N 352	Continued From page 45 insulin not administered, as prescribed. On 08/29/2024 at 10:19 A.M., Surveyor observed Caregiver O sitting in a chair located near the back patio door and looking down at a phone. Surveyor asked Caregiver O about Resident 2's blood glucose monitoring. Caregiver O told Surveyor Resident 2's blood glucose was to be checked on an "as needed" basis, not scheduled, and that was why s/he did not check his/her blood glucose this morning. On 08/29/2024, Surveyor reviewed Resident 2's August 2024 MAR including practitioner's orders, as provided by House Manager B. Resident 2's practitioner's orders, as received, included the following directions for Resident 2's omeprazole dose "take 1 capsule by mouth daily before breakfast," for Resident 2's ferrous sulfate dose "take 1 tablet by mouth daily with breakfast," for Resident 2's metformin dose "take 1 tablet by mouth twice daily with meals," and for Resident 2's Humalog insulin dose "inject 6 units subcutaneously [beneath the skin] three times a day before meals. Blood sugar twice daily at 8 A.M. and 5 P.M." On 08/29/2024 at approximately 11:59 A.M., another Surveyor observed Caregiver O begin serving lunch plates to residents seated in the dining room. Resident 2 was then observed eating lunch. At approximately 12:09 P.M., Surveyor observed Caregiver O serve a second helping of lunch to Resident 2. After this, Surveyor briefly interviewed Caregiver O. Caregiver O reported s/he was going to pass the noon medications but was not sure where the other staff member who was supposed to be working was to assist.	N 352		

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N 352	Continued From page 46 On 08/29/2024 at approximately 12:16 P.M., another Surveyor observed Caregiver O begin the noon medication pass. At approximately 12:25 P.M., Surveyor observed Caregiver O at the medication cart. On the laptop screen on top of the cart, Surveyor observed an order displayed for Resident 2's insulin, which indicated that 6 units of insulin were to be administered before meals. Caregiver O confirmed s/he had yet to administer Resident 2's insulin. Surveyor observed that Resident 2 was already finished with lunch and absent from the dining area. Caregiver O was observed inspecting a lancet, which s/he reported was not sure worked. Caregiver O referred to the lancet as Resident 2's "insulin needle," reported that Resident 2 did not have "insulin needles," and stated, "They never have them." Caregiver O reported s/he was not sure if the "insulin needle" worked. Caregiver O spent a couple more minutes looking in the cart and inspecting the lancet. Caregiver O and Surveyor then walked to Resident 2's room and observed him/her sitting on his/her bed watching television. Caregiver O then spent approximately 5 minutes inspecting the lancet again. Caregiver O attempted to poke Resident 2's finger with the lancet, but it did not draw blood. Caregiver O then stated, "I don't understand this stuff. It doesn't work," and left the room. Upon returning to the medication cart, Caregiver O stated that s/he "will have to figure this out." Caregiver O returned the lancet to the medication cart and documented on the laptop that Resident 2 refused his/her lunchtime insulin due to not having insulin needles in the cart. Caregiver O then closed up the medication cart and reported that s/he was done with the lunchtime medication pass. Surveyor observed that Resident 2 did not get his/her blood glucose tested or scheduled insulin administered.	N 352		

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N 352	Continued From page 47 On 08/29/2024 Surveyor reviewed Resident 2's August 2024 MAR, as provided by House Manager B. Resident 2's August MAR included the following documentation by Caregiver O at 12:29 P.M., "Humalog...(as prescribed) no pass reason: Refused. No insulin needles in med [medication] cart. Blood sugar tools are not working." On 08/29/2024 at approximately 12:40 P.M., Surveyor interviewed Resident 2. Resident 2 reported that staff were "supposed to" test his/her blood sugar before his/her meals but they typically tested it after s/he already ate. Resident 2 reported s/he had an arm sensor that could be used with a meter to read his/her blood sugar, but the caregivers typically waited until the sensor died before reordering, which meant the caregivers would have to prick his/her finger in the meantime. Resident 2 reported that half of the time the caregivers could not get the lancet to work and s/he thought some caregivers did not know how to use it. On 08/29/2024 at 12:24 P.M., Surveyor conducted an interview with House Manager B regarding Resident 2. House Manager B told Surveyor Resident 2 was an accurate historian. House Manager B told Surveyor Resident 2 was admitted to the facility from his/her own home because Resident 2 was not taking his/her medications correctly on his/her own. House Manager B said Resident 2 has diagnoses including diabetes and required daily insulin injections. House Manager B told Surveyor Resident 2's blood glucose monitoring was not ordered "as needed" but rather prescribed to be checked before Resident 2 was administered insulin and before Resident 2 was served a meal.	N 352		

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N 352	Continued From page 48 House Manager B told Surveyor Resident 2 should be administered all medications as prescribed by his/her practitioner. Example 2: Resident 5 On 08/29/2024, at approximately 8:05 a.m., breakfast consisting of cereal, toast, and bananas was served to residents, including Resident 5 seated in the facility's dining room. On 8/29/2024 at 9:03 A.M., Surveyor observed Caregiver O prepare to administer Resident 5's medications approximately one-half hour after Resident 5 completed breakfast. Caregiver O dispensed the following medications into a small medication cup: a levothyroxine 75 mcg (microgram) tablet, 2 acetaminophen (Tylenol) 325 mg (milligram) tablets, a chewable tablet of aspirin 81 mg, a carvedilol (cardiac medication) 3.12 mg tablet, a furosemide (Lasix; diuretic medication) 20 mg tablet, and a spironolactone (cardiac medication) 25 mg tablet. Caregiver O told Surveyor, "This is all s/he gets" before leaving the medication room with Resident 5's dispensed medications. Caregiver O approached Resident 5 seated at a dining room table with a glass of water and Resident 5's medications in the medication cup. Resident 5 looked at the medications in the cup and declined to take them. Caregiver O returned to the medication cart located in the medication room with Resident 5's dispensed medications and stated, "I [Caregiver O] think they crush [his/her] meds [medications], but I do not know what they put them in." Caregiver O stated, "I'll have to get a yogurt from the kitchen." Surveyor observed Caregiver O place Resident 5's tablets from the medication cup into a small, clear bag and crush all of the medication. Caregiver O opened the protective	N 352		

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seal of an entire individual serving container of yogurt and placed Resident 5's crushed medications on top of the yogurt and began to stir the medications into the top portion of the yogurt. Caregiver O approached Resident 5 with a spoonful of the crushed medications in yogurt and Resident 5 declined to ingest the mixture. Surveyor observed Caregiver O return to the medication cart and document in Resident 5's MAR "refused" for all of the medications Caregiver O attempted to administer to Resident 5 and "[Resident 5] stated [s/he] doesn't [sic] want to take them" for all the medications except aspirin 81 mg.
Surveyor reviewed Resident 5's August 2024 MAR including practitioner's orders, as provided by House Manager B. Resident 5's practitioner's orders, as received, did not include an order to crush Resident 5's medications. Resident 5's practitioner's orders included the following direction for Resident 5's levothyroxine dose, "Take 1 tablet by mouth every morning on empty stomach for hypothyroidism."

On 08/29/2024 at 4:02 P.M., Administrator M and Surveyor reviewed Resident 5's medications, including documentation of Resident 5's practitioner's orders and Resident 5's MAR. Administrator M told Surveyor s/he was unable to locate an order to crush Resident 5's medications within Resident 5's practitioner's orders. Administrator M told Surveyor Resident 5's medications should not be crushed before administration.

Example 3: Resident 11

On 08/29/2024, at approximately 8:05 A.M., breakfast consisting of cereal, toast, and bananas was served to residents, including Resident 11

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N 352	Continued From page 50 seated in the facility's dining room. On 8/29/2024 at 9:08 A.M., Surveyor observed Caregiver O prepare to administer Resident 11's oral, tablet medications approximately one-half hour after Resident 11 completed breakfast. Caregiver O dispensed the medications into a small medication cup and removed a tube of Baza barrier cream labeled for Resident 11 from the medication cart. Caregiver O approached Resident 11 seated at a dining room table with a glass of water and handed the cup of dispensed medications to Resident 11. Resident 11 consumed all of the oral, tablet medications dispensed by Caregiver O. Following the administration of Resident 11's oral medications in tablet form, Caregiver O applied the barrier cream to Resident 11's buttocks in the nearest bathroom. Caregiver O returned to the medication cart and documented administration of Resident 11's medications at 9:31 A.M. Surveyor observed Caregiver O look through the medication cart before telling Surveyor s/he was not able to locate Resident 11's Deep Sea nasal spray and Lubriderm lotion, as prescribed. Surveyor observed Caregiver O did not dispense and/or administer Resident 11 any medications in powdered form to be mixed with a liquid for administration, such as polyethylene glycol [a bowel medication], any nasal sprays, moisturizing lotion, or liquid nutrition drinks. On 08/29/2024, Surveyor reviewed Resident 11's August 2024 MAR including practitioner's orders, as provided by House Manager B. Resident 11's practitioner's orders, as received, included the following prescribed medications not administered by Caregiver O despite being documented as administered at 9:31 A.M. on 08/29/2024 within Resident 11's MAR:	N 352		

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N 352	Continued From page 51 polyethylene glycol powder "mix 1 capful with 6 oz [ounces] of prune juice and take by mouth daily for constipation...," and Ensure, a nutritional supplement "drink 1 bottle by mouth every morning (vanilla or strawberry)..." On 08/29/2024 at 4:02 P.M., Administrator M and Surveyor reviewed Resident 11's medications, including documentation of Resident 11's practitioner's orders and Resident 11's MAR. Resident 11's practitioner's orders, as received, included the following prescribed medications not administered by Caregiver O despite being documented as administered at 10:20 A.M. on 08/29/2024 within Resident 11's MAR: Deep Sea 0.65% nasal spray "instill 2 sprays in each nostril twice a day" and Lubriderm lotion "Apply topically to both lower extremities daily." Surveyor observed Administrator M remove an entire container of Lubriderm lotion labled with Resident 11's name and dated "02/12/2024." Administrator M said Caregiver O did not apply this lotion to Resident 11, as prescribed and documented, because this container had never been opened. Surveyor observed Administrator M search the entire medication cart before Administrator M told Surveyor Caregiver O did not administer Resident 11's nasal spray, as prescribed and documented, because Resident 11's nasal spray was not available. Surveyor discussed with Administrator M Caregiver O's documentation of administration of Resident 11's polyethylene glycol dose and Resident 11's Ensure dose at 9:31 A.M. on this morning without administering to Resident 11, as prescribed. Administrator M told Surveyor Resident 11 did not have Ensure available for administration and Resident 11 should be administered the polyethylene glycol, as prescribed.	N 352		

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N 352	Continued From page 52 Example 4: Resident 14 On 08/29/2024 at approximately 9:39 A.M., Surveyor observed Caregiver O prepare to administer Resident 14's medications. Caregiver O dispensed Resident 14's oral medications into a small medication cup, including 2 tablets of acetaminophen 500 mg and a pantoprazole (a gastroesophageal reflux disorder medication) 20 mg tablet, despite neither medication being listed within Resident 14's electronic MAR. Surveyor observed Caregiver O did not dispense a pantoprazole 40 mg tablet and a Vitamin D3 tablet into Resident 14's medication cup. Caregiver O told Surveyor these 2 medications were not prescribed for Resident 14 based on review of Resident 14's electronic MAR. Surveyor observed Caregiver O search through the medication cart before Caregiver O said s/he was looking for Resident 14's fluticasone 50 mcg nasal spray but this medication was "not in med cart." Surveyor observed Caregiver O document, "No pass reason: Refused, not in med cart" regarding Resident 14's prescribed fluticasone nasal spray at 9:39 A.M. Surveyor observed Caregiver O take Resident 14's medications, as dispensed, to Resident 14's bedroom and administer them to Resident 14 with a glass of water. Surveyor observed Caregiver O return to the medication cart and document administration of Resident 14's medications, as dispensed, at 9:42 A.M. Surveyor observed Caregiver O did not administer any inhalers to Resident 14 during this medication pass observation. On 08/29/2024, Surveyor reviewed Resident 14's August 2024 MAR including practitioner's orders, as provided by House Manager B. Resident 14's practitioner's orders, as received, included the following prescribed medications not	N 352		

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administered by Caregiver O despite being documented as administered at 9:42 A.M. on 08/29/2024 within Resident 14's MAR: pantoprazole 40 mg tablet prescribed on "08/20/2024" and "take 1 tablet by mouth daily," and Vitamin D3 prescribed on "08/19/2024" and "take 1 tablet by mouth every morning for supplement." Resident 14's practitioner's orders, as received, included the following medications administered by Caregiver O on 08/29/2024 despite being discontinued on "08/20/2024": 2 tablets of acetaminophen 500 mg and a pantoprazole 20 mg tablet.

On 08/29/2024 at 4:02 P.M., Administrator M and Surveyor reviewed Resident 14's medications, including documentation of Resident 14's practitioner's orders and Resident 14's MAR. Administrator M and Surveyor reviewed a practitioner's order for Resident 14 to receive Spiriva 2.5 mcg (a respiratory inhaler) "inhale 2 puffs into the lungs every morning" with a documented start date of "07/31/2024." Resident 14's MAR included Caregiver O's documentation of administration of this inhaler to Resident 14 at 9:42 A.M., despite not having administered this medication to Resident 14. Administrator M reviewed the medication cart and located a Spiriva inhaler tabled with Resident 14's name and date of "07/31/2024." Administrator M demonstrated and stated to Surveyor this inhaler "had not been used" and "remained full with 60 doses remaining" on the inhaler's dose counter dial. Administrator M told Surveyor this inhaler "should be half gone by now." If administered, as prescribed, this inhaler should have been almost completely used had 2 inhaled puffs been administered per day since 07/31/2024. Based on review of Resident 14's August 2024 MAR, caregivers had documented administering

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N 352	Continued From page 54 Resident 14's Spiriva inhaler, as prescribed, every morning since 08/01/2024, with the exception of Resident 14's absence from the facility for 4 consecutive mornings related to a documented hospitalization. Surveyor observed Administrator M review the medication cart and locate Resident 14's fluticasone 50 mcg nasal spray despite Caregiver O not administering this prescribed nasal spray to Resident 14 on 08/29/2024 because Caregiver O documented it was "not in med cart." Administrator M reviewed Resident 14's-unit dose packages of acetaminophen 500 mg and pantoprazole 20 mg located within the medication cart and told Surveyor these medications should not have been administered by Caregiver O on 08/29/2024 because they had been discontinued on 08/20/2024. Administrator M said Caregiver O should have administered 40 mg of pantoprazole, not 20 mg as observed during medication pass observation. On 08/29/2024 at 4:02 P.M., Administrator M and Surveyor discussed the aforementioned concerns regarding the observations and record review surrounding Resident 2's, Resident 5's, Resident 11's, and Resident 14's prescribed medications, including observations of Caregiver O's morning and noon medication pass process on 08/29/2024. Administrator M told Surveyor s/he had been the administrator of the facility for approximately 2 weeks after Former Administrator A had terminated employment with the facility. Administrator M told Surveyor Facility Nurse N completed a medication room/cart monthly audit on 08/27/2024, a document provided to Surveyor by House Manager B. Administrator M said concerns documented on audit would need to be addressed and s/he planned on removing Caregiver O from	N 352		

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N 352	Continued From page 55 medication administration duties until Caregiver O was provided additional training. Administrator M said additional medication administration training would be provided to other caregivers responsible for medication administration, as well. Administrator M told Surveyor s/he needed to leave the facility for personal reasons after this interview. Surveyor informed Administrator M the Surveyors would conduct an exit interview with House Manager B in Administrator M's absence before leaving the facility. Administrator M told Surveyor, "[House Manager B] will let me know." On 08/29/2024, at approximately 8:18 p.m., Surveyors conducted an interview with House Manager B, including a discussion regarding resident medication administration concerns. Surveyors observed House Manager B appeared to take notes but did not reply to these concerns during this interview. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws	N 352		
N 362	83.33(1)(d) Grievance procedure: written summary The CBRF shall provide a written summary of the grievance, the findings and the conclusions and any action taken to the resident or the resident ' s legal representative and the resident ' s case manager. The CBRF shall maintain a copy of the investigation. This Rule is not met as evidenced by: Based on record review and interview, the	N 362		

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provider did not ensure that a written summary of grievances including Resident 8's care needs and laundry procedures as well as their resulting conclusion(s) and action(s) taken were provided to his/her legal representative and case manager.

The findings include:

On 08/29/2024, at approximately 8:18 p.m., Surveyor interviewed House Manager B. House Manager B reported s/he was aware of different care concerns brought up by Family Member W regarding Resident 8's cares when Resident 8 resided with the provider. House Manager B reported s/he recalled one occasion shortly after Resident 8's move-in that Family Member W complained to Former Administrator A about staff not changing Resident 8. House Manager B reported s/he was also aware of other concerns raised by Family Member W including Resident 8 frequently being wet, Resident 8's call light having issues, and Resident 8 not participating in activities. House Manager B reported s/he was pretty sure s/he recalled Family Member W being upset about Resident 8's cares and that these concerns were discussed during a care conference that included him/her, Former Administrator A, and Resident 8's managed care organization (MCO) team. House Manager B reported s/he did not think any notes were taken by the provider's staff regarding this conference and what was discussed. House Manager B confirmed s/he did not have any grievances documented regarding Resident 8.

On 09/04/2024, at approximately 12:01 p.m., Surveyor interviewed Nurse Case Manager DD, who was part of Resident 8's managed care organization (MCO) team. Nurse Case Manager DD reported that care concerns for Resident 8

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were discussed during approximately 2-3 in-person meetings that Resident 8's MCO team had with the provider's staff as well as in several e-mail exchanges with the provider's staff - including Former Administrator A and House Manager B. Nurse Case Manager DD reported that these concern areas included lack of toileting and grooming. Nurse Case Manager DD reported being aware of concerns raised regarding Resident 8 missing bedsheets on one occasion which had been brought up to the MCO case managers as well as the provider's staff. Nurse Case Manager DD reported that sometimes staff would report following up with the concerns raised but the follow-up actions would not really occur.

On 09/04/2024, Surveyor reviewed e-mails provided by Nurse Case Manager DD showing correspondence between Resident 8's managed care organization (MCO) representatives, Nurse Case Manager DD and Case Manager EE, and various provider staff, related to concerns identified with Resident 8's cares. Surveyor observed the following:

1) An e-mail sent by Nurse Case Manager DD to Former Administrator A, Case Manager EE, Former Facility Registered Nurse (RN) FF, Former Facility Licensed Practical Nurse (LPN) S, House Manager B, and Former Caregiver II on 03/19/2024 at 9:08 a.m. The e-mail documented, "[Family Member W] states [Resident 8] does not have any more incontinence products. When [Resident 8] is about to run out of incontinence products the facility is responsible for calling [company] to order more ...I called today to make sure [s/he] can get some soon ...Also wanted to follow up about [Resident 8]'s showers and [his/her] shaving. [Family Member W] does not think these two things are happening. [Family

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Member W] stated [s/he] has shaved [Resident 8] the last two weeks. Can we make sure [Resident 8] is getting showered and shaved?" The reply by Administrator A documented, "I will keep a look out for the supplies. I will double check on the showers and shaving." No other follow up was e-mailed by the provider's staff, as evidenced by the next e-mail exchange in the thread being the e-mail exchange below.

2) An e-mail sent by Case Manager EE to the same staff identified above, on 04/12/2024 at 9:30 a.m., which documented, " ...What can we do to ensure that [Resident 8] is getting [his/her] shower and shaved? [Resident 8] likes to be clean shaven." The reply by Administrator A documented, " ...I will have [House Manager B] and [Former Caregiver II] make sure being shaved EVERY shower day in [his/her] daily tasks."

3) An e-mail sent by Case Manager EE to Former Administrator A, House Manager B, Former Facility LPN S, and Former Caregiver II on 04/23/2024 at 8:26 a.m. The e-mail documented, " ...[Former Administrator A] - I know you have spoken with [Family Member W] recently and [s/he] has expressed ongoing concerns regarding [Resident 8]'s care. It appears to be all basic care needs that continue to just not happen ..."

On 09/04/2024, at approximately 4:30 p.m., Surveyor interviewed Family Member W. Family Member W reported that during Resident 8's admission there were 3 or 4 care meetings to discuss the various care concerns s/he had - which included concerns regarding Resident 8's lack of nail care, shaving, and incontinence cares. Family Member W reported that the same concerns were brought up and discussed every

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meeting. Family Member W reported that Former Administrator A participated in at least 2 of the meetings and House Manager B participated in some of them, too. Family Member W reported that the lack of cares were brought up at all care conferences but "were never resolved" and persisted up until the time that Resident 8 passed away. Family Member W also reported having discussed with staff concerns related to the facility's laundry procedures. Family Member W stated that laundry "was a nightmare since day one." Family Member W clarified that Resident 8 would frequently have shirts on or in his/her closet that didn't belong to him/her, and that s/he would be frequently missing his/her bed linens. Family Member W also reported that at one point staff told him/her that Resident 8 had no more socks left, and so s/he had to buy more for him/her. Family Member W reported that one time s/he visited Resident 8 and observed s/he was wearing a shirt which did not belong to him/her that didn't even cover his/her belly. Family Member W reported s/he even bought a label maker and put Resident 8's name on his/her clothes but this didn't seem to help. Family Member W reported that when s/he discussed missing clothes/linens with staff they would apologize and say they would look for the missing items. Family Member W reported s/he would not hear any sort of follow up, however, and because of this started taking it upon him/herself to go through residents' clothes in the laundry room to search for Resident 8's clothes/linens anytime they appeared to be missing. Family Member W reported that s/he never received any sort of documented responses by staff regarding the care and laundry concerns s/he brought up - including written summaries of his/her concerns or conclusions and resulting actions taken in response to the concerns.

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N 362	Continued From page 60 On 09/04/2024, Surveyor reviewed screenshots of text message exchanges between Family Member W and Former Administrator A, provided by Family Member W, and observed the following regarding the care and laundry-related concerns raised for Resident 8: 1) One text conversation, starting on 12/03/2023 at 4:48 p.m. Family Member W texted, "Hi [Administrator A] sorry to bother you but [Resident 8]'s laundry is missing they have [his/her] tote in the laundry room empty [s/he] had new sheets that I just bought [him/her] pants and a few shirts ...can you call me in the morning thanks ..." The reply that day by Former Administrator A documented, "[Oh my god (OMG)] what?" The reply that day by Family Member W documented, "Yeah if you could call me tomorrow morning don't mean to bother you on Sunday have a few concerns." Former Administrator A's next reply was, "Absolutely." 2) One text, sent by Family Member W on 12/10/2023 at 4:19 p.m.: "Hi [Former Administrator A] so I see [Resident 8] is also missing 4 of the same pillow cases did you look in the linen closet to see if that sheet was in there. I don't know why this pillow cases are miss [sic]." A follow up text was sent by Family Member W on 12/19/2023 at 7:23 a.m.: "Hi [Former Administrator A] ...I also looked in your linen closet and found two of [his/her] sheets and [his/her] pillowcases." Administrator A replied to an unrelated conversation but did not address any missing linens. 1) One text conversation, starting on 02/17/2024 at 1:13 p.m. Family Member W texted, "Hi [Former Administrator A] I just got back from my	N 362		

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vacation and came to see [Resident 8] on our care plan meeting [s/he]'s supposed to be cleanly shaven is not shaven for an over a week!!!!! And [his/her] diaper is full of piss and [his/her] bed is wet as well, what's going on [Former Administrator A]?" After this text, Family Member W then sent a picture of Resident 8 in which Surveyor observed him/her to have grown-out facial hair on his/her upper lip, chin, and jawline. Sureyor did not observe a follow up response from Former Administrator A.

2) One series of exchanges, starting on 04/18/2024 at 6:26 p.m. Family Member W texted, "Hi [Former Administrator A], sorry to bother you so can I have someone clip [Resident 8]'s toenails and [his/her] fingernails? They're really long looks like they have not been done for a while. I would greatly appreciate that. Thank you." The reply sent that day from Former Administrator A was, "I apologize. I'll have them done."

The next day, 04/19/2024, at 3:14 p.m., Family Member W texted, "Hi [Former Administrator A], sorry to bother you again. I know you said you would have someone take care of [Resident 8]'s fingernails and toenails. I went there again just now nothing's been done and I want to bring to your attention as well that [Resident 8] has clothes missing clothes that don't belong to [him/her]. [S/he] had a shirt on that didn't even fit [him/her]. [His/her] belly was showing, [s/he] doesn't have any socks that [s/he] came with but one pair in [his/her] drawer. I just need to get to the bottom of this and why [s/he] doesn't have [his/her] clothes. I'm gonna call [Case Manager EE] and see if we can get another Care meeting planned or scheduled because I don't think that things are being taken care of the way they

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should be, let me know if you get any questions. Thank you." The reply sent that day from Former Administrator A was, "I agree about having another care meeting."

The next text, sent by Family Member W on 04/22/2024 at 5:53 p.m., documented, "Hi [Former Administrator A, sorry to bother you again but today is Monday. I just stopped by [Resident 8]'s and from our last message I sent that [his/her] fingernails and toenails were not clipped yet. Today is Monday and they're still not done yet. Hopefully you can clip them or have somebody clip them before we have this Care meeting. I would appreciate it and thank you so very much for understanding."

The next text, sent by Family Member W on 04/27/2024 at 5:44 p.m., documented, "Hi [Former Administrator A], sorry to bother you again but this seems to be an ongoing thing with us. [Resident 8]'s fingernails and toenails are still not clipped. I've got your text messages saying you have somebody right on it ...this is getting beyond bearable so I don't know what it's going to take to have you take care of [Resident 8] the way [s/he] should be and the money [s/he] is paying for to be taken care of the way should be is not as unacceptable [Former Administrator A] ...Had enough of begging you to do what you're supposed to do for [Resident 8] and apparently other residence [sic] that are not being taken care of!!!" The reply that day sent by Former Administrator A was, "The podiatrist doesn't come until june. I'd make an appointment to get them cut prior to that. If they are thick and longer, a podiatrist needs to cut them. [House Manager B] has [his/her] office in apple and is your go to person. I think I said this before. We have had meetings and training with staff and are observing

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them doing their tasks. I'm sorry you feel this way. I really am." Family Member W's next reply was, "We have Care meetings about this and every Care meeting that we have is that they're going to clip [his/her] nails and [his/her] toenails and shave [him/her] and it still doesn't get done. I don't know what you're trying to tell me but it's unacceptable [Former Administrator A]. so [sic] the only thing I'm going to do for now is make sure that it gets done I'll make the phone calls I need to make and there's no need to be sorry I'm sorry that you can't do what you say you're going to do that's what [sic] sorry about it. Unacceptable [Former Administrator A] ...I apologize, but I've asked you nicely numerous times. I've taken pictures. I've sent out an e-mail to [his/her] Care team for [MCO organization] again ...what's really going on [Former Administrator A]? Why are [Resident 8]'s fingernails toenails and not being shaving like the care plan calls for we've had this meeting numerous times [Former Administrator A] and it doesn't ever seem to be taken care of. We'll find out when we have this meeting on Tuesday of where we go next." Former Administrator A's next reply was, "I've written people up, fired people and retrained people. It's aggravating. I'm also in daily contact with the head people of [MCO] provider concerns department." Family Member W's next reply was, "Who is your supervisor? I want their name and people I can contact directly when I have issues that are not being taken care of. Is it the owner? I need to talk to you because I'm done begging for [Resident 8] to be taken care of the way [s/he] should be taken care of and the way we are paying you to take care of [him/her]." Former Administrator A's next reply was, "I'm trying my best. [House Manager B] is trying [his/her] best ...If you're not happy with our services you are welcome to move [Resident 8] out. You're not obligated to stay." Family Member

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W's next reply was, " ...Can you please provide me with your supervisors [sic] name and number so I can talk to them directly thank you." Former Administrator A's next reply was, "I will discuss this further during our care meeting. I am home alone with my kids and there's a bad storm coming. Have a great weekend." Surveyor did not observe a response where Former Administrator A provided Family Member W contact information for staff not involved in his/her concern.

3) One text from Former Administrator A, sent on 04/30/2024 at 5:54 p.m.: "I want to apologize for everything and I'd like to have a chance to work through things ...I really am trying to better things, but when you have uncompliant staff it definitely makes things more challenging."

On 09/06/2024, at approximately 11:08 a.m., Surveyor interviewed Case Manager EE. Case Manager EE reported that throughout Resident 8's entire admission with the provider "there was a lot of concerns about meeting [his/her] basic needs." Case Manager EE reported that care concerns for Resident 8 - including toileting/incontinence needs, shaving, and nail care - were discussed during in-person meetings with the provider's staff. Case Manager EE reported that laundry "was a nightmare also" and that there were ongoing concerns with Resident 8 wearing the wrong clothes (that didn't belong to him/her), not having his/her own clothes, bedding missing, and Resident 8's closet containing clothes that did not belong to him/her. Case Manager EE reported that Former Administrator A and House Manager B were the primary contacts who Resident 8's MCO team contacted about care concerns and that both were "very well aware" of Resident 8's care concerns that persisted throughout his/her admission. Case

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N 362	Continued From page 65 Manager EE stated, "There was absolutely no question that they were aware of the concerns." Case Manager EE reported that despite care concerns being raised about the lack of Resident 8's cares, the actual follow up and resolution to the issues did not seem to occur and the issues persisted throughout Resident 8's admission. Case Manager EE reported that Resident 8's MCO team was never provided any sort of information regarding how staff planned to address the care concerns raised. On 09/06/2024, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider on 11/28/2023 with diagnoses including dementia and bipolar disorder. Resident 8 resided with the provider until s/he passed away on 07/17/2024. Resident 8 was documented on his/her face sheet as having an activated power of attorney (POA) for healthcare. In reviewing Resident 8's individual service plan (ISP), dated 08/29/2024 (day of the survey), Surveyor did not observe any information regarding Resident 8's shaving needs, nail care needs, laundry-related needs, or incontinence with required assistance to manage incontinence products. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan N0425 DHS 83.38(1)(a) Personal Care	N 362		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the	N 386		

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assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that the comprehensive individual service plan (ISP) developed for Resident 8 reflected his/her needs, program services and approaches, methods for delivering care, and who was responsible for delivering the care.

From the start of his/her admission, Resident 8 was known to ambulate with a walker, require assistance with incontinence management, nail care, and shaving; and use a fall mat at night based on provider staff, case manager, and family member interviews as well as his/her pre-admission assessment, e-mail exchanges, and text exchanges. None of this information was in Resident 8's ISP. Case manager report and e-mail exchanges identified that frequent checks were recommended for Resident 8 due to his/her lack of reliability in using his/her call light or requesting assistance for transfers and ambulation. While his/her cognitive deficits and lack of ability to reliably request assistance was documented in his/her ISP, there was no

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information documenting the approach(es) staff were to utilize to address this need. Resident 8's ISP was not reviewed with or signed by his/her legal representative.

This requirement is being cited for the fifth time. See Statement of Deficiency (SOD) UDWF11, issued 02/19/2021, SOD UDWF12, issued 06/17/2021, SOD 54DT11, issued 03/24/2023, and FT8K12, issued 06/16/2023

The findings include:

On 08/29/2024, Surveyors conducted a complaint investigation into concerns of resident care needs not being met.

On 08/29/2024, Surveyor reviewed part of Resident 8's record. Resident 8 was admitted to the provider on 11/28/2023 with diagnoses including dementia, atrial fibrillation, and bipolar disorder. Resident 8 resided with the provider until s/he passed away on 07/17/2024. Resident 8 was documented on his/her face sheet as having an activated power of attorney (POA) for healthcare.

At approximately 1:00 p.m., Surveyor requested from House Manager B both the ISP that was active at the time of Resident 8's passing as well as the comprehensive ISP that was developed in Resident 8's first 30 days of admission, if that was different from the one active at the time of his/her passing.

On 08/29/2024, Surveyor reviewed the single ISP for Resident 8 that was provided by House Manager B. The ISP was dated 08/29/2024 (printed the day of the survey). The ISP documented the following:

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N 386	Continued From page 68 - Under the "Toileting" section: "2 hour toileting [Resident 8] will not let staff know when [s/he] needs to use the bathroom ...Resident requires full assistance from staff to complete toileting tasks. Toileting every 2 hours." - Under the "Ambulation" section: "will transfer on own forgets to use call light. Resident requires staff monitoring and/or reminders and cues when ambulating Resident is a 1 assist with transfers." - Under the "Transferring" section: "Resident has call light to use when wanting to transfer does not remember to use it often and will transfer on own. Resident requires staff assistance to complete transfers." There were no signatures on Resident 8's ISP. Surveyor reviewed Resident 8's pre-admission assessment, provided by House Manager B. The assessment was dated 11/14/2023 and signed as being completed by Former Administrator A. Surveyor observed the following: - Cognition-related sections documented that Resident 8 was "forgetful", experienced "some confusion and has difficulty in remembering details," and, "does not recognize when to make a decision and does not follow directions. Needs assistance regularly." - The "Mobility Status" section documented that Resident 8 used a "standard or wheeled walker." - The "Grooming/Basic Hygiene" section specified that this covered, "Washes hands and face, brushes/combs hair, brushes teeth/dentures, shaves, etc." Resident 8 was documented as	N 386		

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requiring "minimal assistance" to complete these tasks.

- The "Toileting" section documented that Resident 8 required "occasional assistance" and that s/he was "occasionally" incontinent of his/her bladder. The section for his/her bowel incontinence was blank.

Upon comparing the pre-admission assessment with his/her ISP, Surveyor did not observe information about Resident 8's incontinence, needs related to grooming, his/her walker use, or methods for assisting in his/her transfers since s/he was known to have cognitive deficits and not use his/her call light reliably per his/her ISP.

At approximately 5:37 p.m., Surveyor interviewed Caregiver D regarding Resident 8's care needs. Caregiver D reported that throughout Resident 8's admission, s/he required staff assistance for facial shaving, approximately once per week, and nail trimming (both fingernails and toenails), approximately once per month. Caregiver D also reported that Resident 8 was known to have a fall mat throughout his/her admission that staff were to use at night when s/he was in bed to prevent fall-related injuries. Caregiver D reported that throughout Resident 8's admission s/he was known to be incontinent of both his/her bowel and bladder and had near daily incontinence episodes.

At approximately 8:18 p.m., Surveyors interviewed House Manager B. House Manager B confirmed s/he used to have a binder with residents' signed ISPs but was unable to find any signed ISPs for any of the current residents at the facility.

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N 386	Continued From page 70 On 09/04/2024, Surveyor reviewed a self-report that was previously submitted for Resident 8, located in the Department's facility folder. The report was dated 12/26/2023 for a fall that that Resident 8 experienced on 12/23/2023. The report was signed as completed by Former Administrator A. In the body of the report, the following was documented: "[Person W] brought in a body pillow to be placed under fitted sheet, Resident has a fall mat that goes out @ night ..." Surveyor observed that the fall and self-report submission to the Department occurred prior to Resident 8 having been at the facility for 30 days (within the date range of his/her comprehensive ISP). On 09/04/2024, at approximately 12:01 p.m., Surveyor interviewed Nurse Case Manager DD, from Resident 8's managed care organization (MCO) team. Nurse Case Manager DD reported that s/he had been working with Resident 8 for the past 3 years. Nurse Case Manager DD reported that there were expectations outlined from the start of Resident 8's admission that s/he would have assistance from staff to trim his/her nails and conduct shaving. Nurse Case Manager DD reported that this was discussed in both his/her initial and subsequent care conferences. Nurse Case Manager DD reported that Resident 8 was known to be incontinent of both bowel and bladder from even prior to his/her admission and required staff assistance to manage his/her incontinence products. Nurse Case Manager DD reported that the fall mat used for Resident 8 was implemented at the start of his/her admission and was supposed to be set up by staff each night when Resident 8 was in bed. Nurse Case Manager DD reported that Resident 8 was known to use a walker to ambulate even prior to his/her admission. Nurse Case Manager DD reported	N 386		

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that Resident 8 was supposed to receive staff assistance, ranging anywhere from supervision to physical assistance when needed, for all ambulation and transfers throughout his/her admission, because s/he had a history of falls when trying to get up on his/her own. Nurse Case Manager DD reported that s/he was known to attempt self-transfers and ambulate him/herself because s/he was known to not use his/her call light reliably or request staff assistance before getting up.

On 09/04/2024, Surveyor reviewed e-mails provided by Nurse Case Manager DD showing correspondence between Resident 8's managed care organization (MCO) representatives, Nurse Case Manager DD and Case Manager EE, and various provider staff, related to Resident 8's needs. Surveyor observed an e-mail thread that included Nurse Case Manager DD, Case Manager EE, Former Administrator A, and Former Facility Registered Nurse (RN) FF. One e-mail in this thread, sent to the group by Case Manager EE on 11/29/2023 at 10:25 a.m. (one day after Resident 8's admission), documented the following: " ...[Resident 8] tends to present as more capable that [sic] what [s/he] is, so I just want to ensure that [his/her] needs are understood. Just a couple things to note - [Resident 8] needs assistance with cutting [his/her] fingernails, weekly or bi-weekly. [S/he] also needs more assistance with toileting that [sic] [s/he] lets on. [S/he] needs to have frequent checks to ensure [s/he] is clean and dry. [S/he] has some issues with diarrhea and needs help making sure [s/he] is clean ..." The reply e-mail sent by Former Administrator A, was, " ...Thanks for reaching out ..." Subsequent e-mails in this thread identified a proposed care conference for 12/12/2023 to discuss Resident 8's needs and

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supports as well as a confirmation that a care conference was to take place on that day.

Surveyor observed that the e-mails in this thread were within Resident 8's 30-day comprehensive ISP period.

At approximately 4:30 p.m., Surveyor interviewed Family Member W, who was the POA for Resident 8. Family Member W reported that his/her understanding was that staff were to address Resident 8's shaving and nail care needs throughout his/her admission because s/he was told by Former Administrator W that these tasks were part of Resident 8's basic care needs. Family Member W reported that Resident 8 was known to be incontinent for years prior to his/her passing and had required assistance for managing his/her incontinence products even prior to his/her admission to the provider. Family Member W reported that Resident 8 had used a fall mat even prior to his/her admission to the provider, and it was supposed to be used every night throughout his/her admission, because s/he was known to fall out of bed. Family Member W reported that Resident 8 had been known to use a walker for ambulation, even prior to his/her admission. Family Member W reported that s/he never received or got an opportunity to review any ISP from the provider at any point during Resident 8's admission.

In reviewing Resident 8's ISP again, Surveyor did not observe any information that corroborated the reports from Caregiver D, Nurse Case Manager DD, Family Member W, or the e-mail exchange provided by Nurse Case Manager DD with specific regards to Resident 8's fall mat use, shaving needs, nail care needs, walker use, and incontinence with required assistance to manage

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N 386	Continued From page 73 incontinence products. On 09/04/2024, Surveyor reviewed screenshots of text message exchanges between Family Member W and Former Administrator A, provided by Family Member W. One series of exchanges, starting on 12/23/2024 at 8:57 a.m. showed Family Member W expressing concern that Resident 8's fall mat was not being used. The reply by Former Administrator A that day was, " ...I wasn't aware [s/he] had a fall mat ..." In comparing this to the self-report Former Administrator A sent to the Department on 12/26/2023 regarding Resident 8's fall (as detailed above), Surveyor observed that Former Administrator A demonstrated awareness of Resident 8's fall mat use within Resident 8's 30-day comprehensive ISP period. On 09/06/2024, at approximately 11:08 a.m., Surveyor interviewed Case Manager EE, who was the other case manager on Resident 8's MCO team. Case Manager EE confirmed that from the start of Resident 8's admission, s/he required a walker for ambulation, should have been using a fall mat at night for nighttime injury prevention, and required staff assistance for shaving, nail care, and incontinence cares. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws N0362 DHS 83.33(1)(d) Grievance Procedure: Written Summary N0425 DHS 83.38(1)(a) Personal Care	N 386		
N 388	83.35(3)(c) Implement, follow the individual service plan	N 388		

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Implementation. The CBRF shall implement and follow the individual service plan as written.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the individual service plan (ISP) for 1 of 2 residents was implemented and followed as written.

Resident 9's ISP, updated at least as recently as 05/29/2024, directed for his/her vitals (including weights) to be taken monthly, his/her consumption to be monitored for each meal, and bowel movements to be recorded and described daily. There was no evidence of his/her weight taken in June or July 2024, vitals taken in July 2024, or consumption monitored for 96 of 267 meals from 06/01/2024 through 08/28/2024. Staff initialed off on monitoring for Resident 9's bowel movements throughout 06/01/2024 - 08/28/2024, however, nothing else was documented other than the staff initials. The bowel movements were not recorded and by extension, descriptions were not recorded in accordance with his/her ISP. There was no way to tell from the documentation which days/times Resident 9 had bowel movements. Resident 9 was prescribed both oral medications and a suppository on an as-needed (PRN) basis and was documented in his/her ISP to have historic issues with constipation that warranted emergency department treatment as well as a regimen for use of his/her PRN medications to facilitate bowel movements.

The findings include:

On 08/29/2024, at approximately 8:10 a.m., Surveyor observed breakfast in the dining area. Resident 9 was not present for breakfast.

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N 388	Continued From page 75 At approximately 12:01 p.m., Surveyor observed Caregiver O assisting Resident 9 to the table for lunch. Caregiver O pushed Resident 9 in his/her manual wheelchair from his/her room, down the hall, and to a table in the dining area. After eating only a couple of spoonfuls of lunch, Resident 9 was observed trying to leave the area. Caregiver O attempted to physically redirect him/her back to his/her food. Caregiver O then left the dining area, and Resident 9 ambulated him/herself in his/her manual wheelchair using his/her feet back to his/her room. At approximately 12:09 p.m., Surveyor interviewed Caregiver O about Resident 9's eating habits. Caregiver O reported that it was typical for Resident 9 to eat little and that s/he sometimes ate but sometimes didn't. At approximately 12:15 p.m., Surveyor observed Resident 9 back in his/her recliner sleeping. At approximately 1:30 p.m., Surveyor interviewed Social Worker JJ, from Resident 9's hospice team. Throughout the interview, Resident 9 was not observed to participate, even when introduced to Surveyor, and was observed to sit in his/her recliner with his/her eyes closed. Social Worker JJ reported that Resident 9 was known to have a varied appetite and that s/he was known to miss meals sometimes due to sleeping. On 08/29/2024, Surveyor reviewed Resident 9's record. Resident 9 was admitted to the provider on 03/26/2020 with diagnoses including acute diastolic heart failure, paroxysmal atrial fibrillation, and chest pain. Resident 9 was documented as having an activated power of attorney (POA) for healthcare.	N 388		

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N 388	Continued From page 76 Resident 9's individual service plan (ISP) was dated 08/29/2024 (day of the survey) and was not signed with a date last reviewed but Surveyor observed one section that documented, "As of Today 5/29/2024 [s/he] is now on [hospice agency]," indicating that the ISP was at least last reviewed on 05/29/2024 when Resident 9 began hospice services. Surveyor observed in the ISP the following service needs documented: - Under the "Consumption Monitoring" heading: "Resident requires staff to monitor food consumption." This task was indicating as needing to be completed daily at breakfast, lunch, and dinner with the goal of Resident 9 consuming adequate food and proper nutrition. - Under the "Monitor for [Bowel Movement (BM)]" heading: "Monitor and record BM's [sic] per shift, also description of BM examples as follows: ...This is very important because [s/he] has been sent to the hospital more than once for having hard BM's [sic] that cause [him/her] to get pain in which we can prevent [emergency room] visits by giving [him/her] something [as needed] for [his/her] bowel movements to soften the stool and therefore stop these [emergency room] visits ...On the second day of no BM [s/he] will be given [as needed medication] to assist in more normal BM instead of hard pain BM." - Under the "Vitals and Weight" heading: "Vitals and weight are completed monthly and reviewed by [registered nurse]." The vitals listed to be taken included blood pressure, pulse, temperature, respirations, and weight. On 08/29/2024, Surveyor reviewed Resident 9's task administration record (TAR) from 06/01/2024 - 08/28/2024, where staff documented their	N 388		

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tracking of Resident 9's "Vitals and Weight" on one entry line, "Weight" on another entry line, consumption monitoring, and bowel movements. Surveyor observed the following:

- Vitals: No weight documented in June or July. No vitals documented in July.

- Consumption monitoring: Blank entries for 55 of 90 entries in June, 23 of 93 entries in July, and 18 of 84 entries in August (from 08/01/2024 through 08/28/2024)

- Bowel movement monitoring: Staff initialed off on the "Monitor for BM" heading 3 times daily throughout the period reviewed, however, nothing else was documented other than the staff initials. The bowel movements were not recorded and by extension, descriptions were not recorded in accordance with the ISP. There was no way to tell from the information which days/times Resident 9 had bowel movements.

On 08/29/2024, Surveyor reviewed Resident 9's "Vitals History" document from 06/01/2024 - 08/28/2024, which also showed weights and vitals documentation. No weights were documented in June or July. No vitals were documented in July.

On 08/29/2024, Surveyor reviewed Resident 9's current prescriptions, which included the following PRN medications to facilitate bowel movements (as referenced to in his/her ISP):

- Bisacodyl 5 mg tablet, active since 04/24/2024, with instructions to, "Take 1-2 tablets (5-10 mg) by mouth every night at bedtime as needed for constipation."

- Bisacodyl 10 mg suppository, active since

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N 388	Continued From page 78 05/31/2024, with instructions to, "Remove wrapper and insert 1 suppository rectally daily as needed for constipation." On 08/29/2024, Surveyor reviewed Resident 9's observation notes from 05/01/2024 - 08/29/2024 and observed an entry on 07/15/2024 at 6:15 p.m. by Caregiver V, which documented, "Resident was complaining that [his/her] behind hurts. Turns out [s/he] was just constipated PRN was given." On 08/29/2024, at approximately 8:18 p.m., Surveyor interviewed House Manager B. House Manager B confirmed that the vitals history and TARs were where staff documented vitals, weights, bowel movement monitoring, and consumption monitoring for Resident 9. House Manager B acknowledged and appeared to take notes of Surveyor's concern regarding the lack of consistent monitoring for Resident 9 as directed in his/her ISP but said nothing further. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws	N 388		
{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	{N 389}		

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{N 389}	Continued From page 79 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, interview, and observation, the provider did not ensure the individual service plans (ISPs) were updated for 2 of 2 residents reviewed when there were changes in their needs and abilities. Resident 8's ISP was not updated to include an updated denture management plan when s/he began losing his/her dentures or information regarding his/her fall risk and fall risk mitigation interventions after s/he experienced 3 falls during his/her admission. The provider did not have evidence of Resident 9's legal representative having reviewed the ISP for Resident 9, who was admitted back in 2020. Resident 9's current functioning, based on observation and interview with a representative from his/her hospice team, was not reflected in his/her ISP, which documented independence / limited physical assistance required for all basic activities of daily living. Resident 9 was documented to have had 3 unwitnessed falls from June - August 2024 but the only interventions documented to mitigate his/her fall risk were to ensure s/he had proper-fitting footwear and was reminded to use his/her walker. This requirement is being cited for the sixth time. See Statement of Deficiency (SOD) UDWF11, issued 02/19/2021, SOD UDWF12, issued 06/17/2021, SOD 54DT11, issued 03/24/2023,	{N 389}		

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{N 389}	Continued From page 80 SOD FT8K12, issued 06/16/2023 and SOD OCCY11, issued 06/17/2024. The findings include: Example 1 - Resident 8 fall risk and denture management On 08/29/2024, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider on 11/28/2023 with diagnoses including dementia and bipolar disorder. Resident 8 resided with the provider until s/he passed away on 07/17/2024. Resident 8 was documented on his/her face sheet as having an activated power of attorney (POA) for healthcare. Surveyor reviewed all incident reports throughout Resident 8's admission, which documented the following in relation to 3 falls s/he experienced: - 2 incident reports that detailed the same fall experienced by Resident 8 on 12/22/2023 sometime between 10:30 p.m. - 11:02 p.m. Both reports documented that Resident 8 sustained an unwitnessed fall by rolling off his/her bed, and that Resident 8 sustained a facial skin tear/laceration as well as bruising near his/her left eye. One of the reports documented that Resident 8 was taken via emergency medical services (EMS) to the emergency department. - Incident report for a fall that occurred on 02/13/2024 at 8:20 a.m. The report documented, "Resident was found by [resident assistant] when [s/he] was going to [his/her] room to get [him/her] for breakfast. [S/he] was sitting on [his/her] buttock [sic] on top of the cushion in which was in place ...Resident states [s/he] tripping on the cushion which is there to prevent [him/her] from	{N 389}		

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{N 389}	Continued From page 81 getting injured ..." - Incident report for a fall that occurred on 03/05/2024 at 6:10 a.m. The report documented, "[Resident assistant] was just bending down to pull [his/her] pants up and [s/he] lost [his/her] balance or footing and went to the floor landing on [his/her] buttock [sic]. Surveyor reviewed Resident 8's observation notes throughout his/her admission, which documented the following in regards to Resident 8's inconsistent call light use and denture management: - 04/01/2024 (2:00 p.m.): " ...[Family Member W] stopped by to help find [his/her] teeth which were in the residents [sic] room ..." - 07/04/2024 (4:00 p.m.): "resident keeps undressing [him/herself] instead of using call light to ask for help ...if [s/he] has an accident [s/he] will choose [his/her] independence and undress [him/herself]." - 07/16/2024 (6:00 p.m.): "Resident very tired came to all meals [s/he] got up on [his/her] own for dinner without using [his/her] call light we reminded [him/her] to use it. After dinner [s/he] went to room and undressed [him/herself] and laid in bed." At approximately 1:00 p.m., Surveyor requested from House Manager B both the ISP that was active at the time of Resident 8's passing as well as the comprehensive ISP that was developed in Resident 8's first 30 days of admission, if that was different from the one active at the time of his/her passing.	{N 389}		

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{N 389}	Continued From page 82 On 08/29/2024, Surveyor reviewed the single ISP for Resident 8 that was provided by House Manager B. The ISP was dated 08/29/2024 (printed the day of the survey). The ISP documented the following: - Under the "Ambulation" section: "will transfer on own forgets to use call light. Resident requires staff monitoring and/or reminders and cues when ambulating Resident is a 1 assist with transfers." - Under the "Transferring" section: "Resident has call light to use when wanting to transfer does not remember to use it often and will transfer on own. Resident requires staff assistance to complete transfers." - Under the "Oral Health" and "Oral Care" sections: "has dentures staff are to help with cleaning ...Resident wears dentures ..." There was no information regarding Resident 8's fall risk or fall risk mitigation interventions implemented by staff throughout Resident 8's admission. On 08/29/2024, at approximately 8:18 a.m., Surveyors interviewed House Manager B. House Manager B reported s/he was the person responsible for updating residents' ISPs. On 09/04/2024, at approximately 12:01 p.m., Surveyor interviewed Nurse Case Manager DD from Resident 8's managed care organization (MCO) team. Nurse Case Manager DD reported that since Resident 8 was a fall risk and was known to not reliably use his/her call light or ask for help in transferring, s/he had previously recommended for staff to implement frequent checks in order to see if s/he was trying to get	{N 389}		

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him/herself up. Nurse Case Manager DD reported that Resident 8 trying to get up on his/her own was the basis for most of the falls s/he experienced. Nurse Case Manager DD reported that there had also been issues related to Resident 8's dentures and him/her frequently losing them. Nurse Case Manager DD reported that the care team had requested for staff to keep Resident 8's dentures in the medication cart when not in use to prevent them from being lost but this never happened.

On 09/04/2024, Surveyor reviewed e-mails provided by Nurse Case Manager DD showing correspondence between Resident 8's managed care organization (MCO) representatives, Nurse Case Manager DD and Case Manager EE, and various provider staff, related to Resident 8's denture needs. Surveyor observed an e-mail sent by Case Manager EE to Former Administrator A, Nurse Case Manager DD, Former Facility Registered Nurse (RN) FF, Former Facility Licensed Practical Nurse (LPN) S, House Manager B, and Former Caregiver II on 04/12/2024 at 9:30 a.m., which documented, "[Family Member W] reports to us that [Resident 8] is having more trouble with [his/her] dentures and keeping track of them. [Family Member W] is worried they are going to get lost or accidentally thrown away. [Family Member W] has had multiple calls from [Resident 8] who cannot find [his/her] dentures and [s/he] has had to go to the facility to assist in finding them. We were thinking that it would be beneficial if [Resident 8]'s dentures could be kept in the med cart and given to [him/her] in the morning and then put in there after dinner or when [s/he] is done eating for the day. Can you let us know if we can move forward with this plan ..." The reply e-mail from Former Administrator A to the group documented, "Yes, of

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course, we can start keeping [his/her] dentures in the med cart and I will put in [his/her] daily tasks to give in the morning and return to the cart after supper daily ..."

On 09/04/2024, Surveyor reviewed Resident 8's record again. Resident 8's ISP did not document any information regarding this plan for managing Resident 8's dentures and his/her task administration records (TARs) for June and July did not document any tasks related to Resident 8's denture management, other than staff were to "help with cleaning."

On 09/06/2024, at approximately 11:08 a.m., Surveyor interviewed Case Manager EE from Resident 8's MCO care team. Case Manager EE confirmed that s/he had made the recommendation to the provider for Resident 8's dentures to be stored in the medication cart due to issues of him/her having lost the dentures. Case Manager EE reported s/he was not sure if this was ever followed up on.

Example 2 - Resident 9's functional decline and fall risk mitigation interventions

On 08/29/2024, at approximately 8:10 a.m., Surveyor observed breakfast in the dining area. Resident 9 was not present for breakfast.

At approximately 12:01 p.m., Surveyor observed Caregiver O assisting Resident 9 to the table for lunch. Caregiver O pushed Resident 9 in his/her manual wheelchair from his/her room, down the hall, and to a table in the dining area. After eating only a couple of spoonfuls of lunch, Resident 9 was observed trying to leave the area. Caregiver O attempted to physically redirect him/her back to his/her food. Caregiver O then left the dining area

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and Resident 9 propelled him/herself in his/her manual wheelchair using his/her feet back to his/her room.

At approximately 12:09 p.m., Surveyor interviewed Caregiver O about Resident 9's eating habits. Caregiver O reported that it was typical for Resident 9 to eat little and that s/he sometimes ate but sometimes didn't.

At approximately 12:15 p.m., Surveyor observed Resident 9 back in his/her recliner sleeping.

At approximately 1:30 p.m., Surveyor interviewed Social Worker JJ, from Resident 9's hospice team. Throughout the interview, Resident 9 was not observed to participate, even when introduced to Surveyor, and was observed to sit in his/her recliner with his/her eyes closed. Social Worker JJ reported that Resident 9 was known to have a varied appetite and that s/he was known to miss meals sometimes due to sleeping. Social Worker JJ reported Resident 9 required staff assistance for all cares. Social Worker JJ reported that Resident 9 was known to be incontinent. Social Worker JJ reported that a certified nurse assistant (CNA) typically came 2-3 times per week to conduct cares for Resident 9, but these were not always known to be showers. Social Worker JJ reported that Resident 9 had a nurse visit yesterday due to experiencing an onset of hip pain. Social Worker JJ reported that the evaluating nurse observed a bruise on Resident 9's hip and concluded that s/he likely had an unwitnessed fall sometime that day.

On 08/29/2024, Surveyor reviewed Resident 9's record. Resident 9 was admitted to the provider on 03/26/2020 with diagnoses including repeated falls and mild cognitive impairment. Resident 9

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was documented as having a POA. Surveyor reviewed Resident 9's observation notes from 05/01/2024 - 08/29/2024 and observed the following entries that documented 3 falls experienced by Resident 9:

- 06/06/2024 (7:45 p.m.): "Resident had an unwitnessed fall in [his/her] room this evening. [Resident assistant] and nurse heard a cry from residents [sic] room. Resident was laying on [his/her] side on the floor between [his/her] wheelchair and bed. Resident did not sustain any injuries and could not tell us what happened ..."

- 06/10/2024 (10:15 a.m.): "Resident had an unwitnessed fall in [his/her] room this morning. [S/he] stated [s/he] hit [his/her] head but there is not any swelling, bruising etc ..."

- 08/28/2024 (2:00 p.m.): "incident report on file for unwiitnessed [sic] fall." (corroborated report of likely fall as reported by Social Worker JJ during interview documented above)

Surveyor reviewed Resident 9's ISP, dated 08/29/2024 (day of the survey), and observed the following:

- Adaptive equipment use of a walker noted

- Under the "Eating" heading: "Independent with eating" The documented goal was listed as: "To maintain adequate food/nutrition intake and independence with eating." Surveyor did not observe any information regarding required cuing or redirection staff were to utilize in order to assist Resident 9 in promoting intake during meals.

- Under the "Oral Care" heading: "[Resident 9] has own teeth (upper/lower). [Resident 9] is

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independent with task but need [sic] set-up and stand by supervision to ensure task is completed properly ..."

- Under the "Dressing" heading: " ...[Resident 9] is independent with putting on taking of [sic] and fastening up clothing. [Resident 9] may need assistance putting on shoes and socks ..."

- Under the "Grooming" heading: "[Resident 9] requires staff monitoring and/or reminders and cues to complete grooming tasks. [Resident 9] is independent (Washing face, comb hair, shave, use deodorant) [Resident 9] needs set-up and stand by supervision to ensure task is preformed [sic] properly ..."

- Under the "Toileting" headings: One section documented that Resident 9 was "independent with toileting" and another section documented that, "Resident requires partial assistance from staff to complete toileting tasks. Will go on own sometimes but needs help changing depends and clothing when needed."

- Under the "Ambulation" heading: "At times [Resident 9] is unsteady when ambulating, use gait belt for safety and to prevent falls. Independent with ambulation. [Resident 9] is able to ambulate independently with assistance from a walker. [Resident 9] often needs reminds [sic] to use walker ..." Surveyor observed that the recommendation for staff to use a gait belt for assisting in Resident 9's ambulation directly conflicted with information that Resident 9 was independent for ambulation.

- Under the "Fall Risk" heading: "Resident has been identified as a fall risk. Risk for falls - Not using walker. Improper foot wear [sic]. Plan of

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{N 389}	Continued From page 88	{N 389}		

reduction- Remind resident to use walker. Make sure shoes are tied and proper fitting."

- Under the "Transferring" heading: "Independent with transfers. [Resident 9] is able to ambulate and transfer independently with assistance from a walker. [Resident 9] often needs reminds [sic] to use walker."

Surveyor observed that the information from Resident 9's ISP conflicted with the assistance s/he was observed by Surveyor to require (such as that of his/her wheelchair use and feeding cuing) as well as the assistance s/he required for activities of daily living as reported by Social Worker JJ from his/her hospice agency.

Surveyor did not observe any signatures on Resident 9's ISP indicating that it was reviewed.

On 08/29/2024, at approximately 8:18 p.m., Surveyors interviewed House Manager B. House Manager B reported s/he was who was typically responsible for updating resident care plans. House Manager B confirmed s/he used to have a binder with residents' signed ISPs but was unable to find any signed ISPs for any of the current residents at the facility, including Resident 9. House Manager B acknowledged Surveyor's concern that Resident 9's ISP did not seem to be updated to reflect his/her current functioning, including requiring increased staff assistance for all activities of daily living and a manual wheelchair for ambulation, as well as fall risk mitigation interventions given his/her recent falls. House Manager B appeared to take notes of Surveyor's concern but said nothing further.

Cross Reference:
N0196 DHS 83.14(2)(a) Licensee Ensures

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{N 389}	Continued From page 89 Compliance With Laws N0425 DHS 83.38(1)(a) Personal Cares	{N 389}		
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 interview, the provider did not ensure that at least one qualified resident care staff was present in the CBRF during the evening of 07/17/2024 when one or more residents were present. There was not a qualified care staff who was trained in or had job responsibilities including	N 397		

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medication administration who worked second shift on 07/17/2024. That evening, the provider relied on Caregiver V, who was working at a separately licensed CBRF next door, to go to the provider's facility specifically to pass scheduled evening medications.

This requirement is being cited for the third time. See Statement of Deficiency (SOD) UDWF12, issued 06/17/2021, and FT8K11, issued 06/16/2023.

The findings include:

The provider is licensed to serve up to 16 residents within the client groups of emotionally disturbed/mental illness, physically disabled, irreversible dementia/Alzheimer's, and advanced aged.

According to Wis. Admin Code § DHS 83.02(42) "Qualified resident care staff" is defined as "an employee who has successfully completed all of the applicable training and orientation under subch. IV." Within subchapter IV, requirements for orientation training, department-approved training, all employee training, and task-specific training are described.

On 08/29/2024, Surveyors investigated a complaint involving concerns regarding Resident 8's death, which occurred on the evening of 07/17/2024. Surveyor reviewed the staff schedule for second and third shifts on 07/17/2024, which documented first shift as occurring from 7:00 a.m. - 3:00 p.m., second shift from 3:00 p.m. - 11:00 p.m., and third shift from 11:00 p.m. - 7:00 a.m. Surveyor observed the following staff who worked sometime during second and third shifts on 07/17/2024:

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N 397	Continued From page 91 - Caregiver D: 3 hours worked between 3:00 p.m. - 11:00 p.m. and 0.3 hours from 11:00 p.m. until 7:00 a.m. on 07/18/2024 (specific times worked not documented) - Caregiver F: 0.3 hours worked between 3:00 p.m. - 11:00 p.m. (specific time worked not documented) - Former Caregiver T: 4.5 hours from 3:00 p.m. - 11:00 p.m. (specific time worked not documented) - Caregiver U: 7.5 hours from 11:00 p.m. - 7:00 a.m. on 07/18/2024 (specific time worked not documented) - Caregiver R: 0.3 hours from 7:00 a.m. - 3:00 p.m. and 3.3 hours from 3:00 p.m. - 11:00 p.m. (specific times worked not documented) At approximately 2:30 p.m. Surveyor interviewed House Manager B about the staff schedule. House Manager B reported s/he saw staff on the schedule for the evening of 07/17/2024 that did not actually work. Surveyor then requested the timecards for staff that worked during second and third shift times on 07/17/2024 in order to specifically see which staff worked during which times. From the timecards provided by House Manager B, the following staff were shown as working during the second and third shifts of 07/17/2024: - Caregiver F: 7:01 a.m. - 3:13 p.m. (corroborated with the 0.3 hours worked during second shift as shown on the staff schedule) - Former Caregiver T: 2:59 p.m. - 7:30 p.m. (corroborated with the 4.5 hours worked during second shift as shown on the staff schedule) - Caregiver R: 3:07 p.m. - 6:18 p.m. (corroborated with the approximate 3.3 hours worked during	N 397		

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second shift as shown on the staff schedule) - Caregiver U: 11:25 p.m. - 7:06 a.m. on 07/18/2024 (corroborated with the 7.5 hours worked during third shift as shown on the staff schedule)

There was no timecard information for Caregiver D. At approximately 2:40 p.m., House Manager B reported s/he could not find any timecard for Caregiver D that evening and reported s/he didn't think s/he worked then. House Manager B reported that s/he thought Caregiver D showed up on the schedule because s/he came to say his/her goodbyes to Resident 8 upon him/her passing that evening.

Between the staff schedule and timecard data, no one was shown as working at the facility from 7:30 p.m. until 11:25 p.m.

At approximately 5:37 p.m., Surveyor interviewed Caregiver D. Caregiver D confirmed s/he came into work that day because s/he was notified about Resident 8's passing and wanted to express his/her condolences to his/her family who had arrived on site that evening. Caregiver D reported s/he arrived to the facility at approximately 7:00 p.m. Caregiver D confirmed that Caregiver R had already left earlier that evening (corroborating his/her timecard) and that Former Caregiver T was who was working the floor during that shift. Caregiver D reported that Former Caregiver T was not a medication passer. Caregiver D reported that Caregiver V, who was working at one of the provider's other licensed CBRFs, was on site and that s/he had specifically come down to the provider's facility to pass scheduled medications that evening.

Surveyor reviewed the staff schedule again,

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which showed that Caregiver V was the scheduled medication passer at Cottages of Madison Elmwood, a CBRF located next door.

On 08/29/2024, Surveyor verified that Former Caregiver T was not on the Community-Based Care and Treatment training registry for medication administration. Upon reviewing the staff schedule and timecard data again, Surveyor observed that Former Caregiver T was working alone on 07/17/2024 from 6:18 p.m. (when Caregiver R clocked out) until an unknown and undocumented time for an undocumented period when Caregiver V had arrived from a different CBRF to pass scheduled evening medications for the provider's residents.

On 08/29/2024, Surveyor reviewed a sample of 2 residents, both of whom were prescribed as-needed (PRN) medications that were active on 07/17/2024:

1) Resident 8, who had diagnoses including knee pain
- Acetaminophen 500 mg tablets with instructions to, "Take 2 tablets (1000 mg) by mouth twice a day as needed for pain / fever ..."
- Antacid 400-400-40 mg / 10 mL oral suspension with instructions to, "Take 30 mL by mouth every six hours as needed for heartburn ..."
- Antacid 750 mg chews with instructions to, "Chew 1 tablet by mouth twice a day as needed for heartburn."
- Diclofenac 1% gel with instructions to, "Apply 2 grams to the affected area four times a day as needed."
- Nyamyc 100 mu / gm powder with instructions to, "Apply topically to affected area on groin and abdominal folds three times a day as needed."
- Muscle rub 10-15% cream with instructions to,

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"Apply topically to the affected area four times a day as needed."

2) Resident 9, who had diagnoses including unspecified chest pain, hypertensive heart disease with heart failure, and major depressive disorder, and who was also documented as being on hospice services
- Nitroglycerin 0.4 mg sublingual tablets with instructions to, "Take 1 tablet under the tongue every 5 minutes as needed for chest pain ..."
- Acetaminophen 500 mg tablets with instructions to, "Take 2 tablets (1000 mg) by mouth three times a day as needed for pain ..."
- Meclizine 25 mg chews with instructions to, "Chew 1 tablet by mouth three times a day as needed for dizziness."
- Ondansetron 4 mg tablets with instructions to, "Dissolve one tablet on tongue every 8 hours as needed for nausea."
- Hyoscyamine 0.125 mg tablets with instructions to, "Take 1 tablet by mouth every 2 hours as needed for terminal secretions."
- Lorazepam 0.5 mg tablets with instructions to, "Take 1 tablet by mouth every 1 hour as needed for anxiety, agitation, restlessness."
- Morphine sulfate 20 mg/mL solution with instructions to, "Take 0.5 mL (10 mg) by mouth every hour as needed for severe pain, shortness of breath."

In reviewing the July medication administration record (MAR) for Resident 9, who had scheduled medications documented to be given around approximately 5:00 p.m. and 8:00 p.m., Surveyor observed that Caregiver V had initialed off on administering all of Resident 9's evening medications.

At approximately 8:18 p.m., Surveyor interviewed

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N 397	Continued From page 95 House Manager B about the staffing concerns the evening of 07/17/2024. House Manager B confirmed that Caregiver V had come from a different building (separately licensed CBRF) specifically to pass scheduled medications during second shift on 07/17/2024 because there was no medication passer working with the provider that that shift. House Manager B confirmed that Former Caregiver T was not trained in medication administration and that s/he had pulled Caregiver R from medication administration duties sometime prior to 07/17/2024 due to suspected concerns with his/her medication administration abilities. House Manager B acknowledged Surveyor's concern that there was not a qualified care staff at the facility during second shift on 07/17/2024 and reported s/he was unaware that a qualified care staff, including one who was trained in medication administration, was required to be working at each separately licensed CBRF. House Manager B reported s/he thought the provider could have a floating medication passer that worked between the provider's 3 separately licensed CBRFs. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule	N 397		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked.	N 399		

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N 399	Continued From page 96 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that a current written schedule for the CBRF's staffing was maintained that contained employees' time worked. The findings include: Example 1 - Partial shift times not specified On 08/29/2024, Surveyor reviewed the staff schedules for July and August 2024, provided by House Manager B. The schedule showed that for caregiving staff, shifts were broken into first, second, and third, with first shift as occurring from 7:00 a.m. - 3:00 p.m., second shift from 3:00 p.m. - 11:00 p.m., and third shift from 11:00 p.m. - 7:00 a.m. Surveyor observed that each shift totaled 8.0 hours. Surveyor observed that the schedules for caregiving staff were formatted such that they documented the employee's name, the shift time, the building worked (of the licensee's 3 separately licensed CBRFs) and the position worked. For each day of the month, listed in separate columns, the number of hours worked was documented. Surveyor observed that for occasions when caregiving staff were documented as working less than 8 hours (less than a full shift), the specific times they worked within the shift was not documented. This included the following: 1) Caregiver V - 07/04/2024: 6.0 hours worked between 7:00 a.m. - 3:00 p.m., specific time worked not documented - 07/31/2024: 6.3 hours worked between 3:00 p.m. - 11:00 p.m., specific time worked not	N 399		

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N 399	Continued From page 97 documented - 08/07/2024: 6.0 hours worked between 3:00 p.m. - 11:00 p.m., specific time worked not documented 2) Caregiver Q - 07/24/2024: 6.5 hours worked between 3:00 p.m. - 11:00 p.m., specific time worked not documented 3) Caregiver X - 07/24/2024: 2.8 hours worked between 3:00 p.m. - 11:00 p.m., specific time worked not documented 4) Caregiver Y - 07/11/2024: 6.8 hours worked between 7:00 a.m. - 3:00 p.m., specific time worked not documented - 08/06/2024: 1.0 hours worked between 7:00 a.m. - 3:00 p.m., specific time worked not documented - 08/07/2024: 3.3 hours worked between 7:00 a.m. - 3:00 p.m., specific time worked not documented 5) Caregiver D - 07/11/2024: 5.0 hours worked between 7:00 a.m. - 3:00 p.m., specific time worked not documented 6) Caregiver U - 07/04/2024: 7.0 hours worked between 7:00 a.m. - 3:00 p.m., specific time worked not documented 7) Caregiver Z - 07/20/2024: 5.0 hours worked between 3:00 p.m. - 11:00 p.m., specific time worked not documented	N 399		

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N 399	Continued From page 98 8) Caregiver AA - 07/15/2024: 4.0 hours worked between 3:00 p.m. - 11:00 p.m., specific time worked not documented 9) Caregiver BB - 08/05/2024: 4.8 hours worked between 7:00 a.m. - 3:00 p.m., specific time worked not documented - 08/13/2024: 4.0 hours worked between 7:00 a.m. - 3:00 p.m., specific time worked not documented - 08/24/2024: 5.0 hours worked between 7:00 a.m. - 3:00 p.m., specific time worked not documented 10) Caregiver CC - 08/07/2024: 2.5 hours worked between 3:00 p.m. - 11:00 p.m., specific time worked not documented - 08/13/2024: 4.0 hours worked between 7:00 a.m. - 3:00 p.m., specific time worked not documented 11) Caregiver K - 08/19/2024: 6.3 hours worked between 3:00 p.m. - 11:00 p.m., specific time worked not documented At approximately 2:30 p.m. Surveyor interviewed House Manager B about the staff schedule. House Manager B confirmed that the staff schedule didn't clarify the times that partial shift hours were worked, and reported that individual timecards would have to be reviewed to confirm what times within their shifts partial shifts were worked by employees. Example 2 - Evening of 07/17/2024	N 399		

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N 399	Continued From page 99 On 08/29/2024, Surveyors investigated a complaint involving concerns regarding Resident 8's death, which occurred on the evening of 07/17/2024. Surveyor reviewed the staff schedule for second and third shifts on 07/17/2024, which documented first shift as occurring from 7:00 a.m. - 3:00 p.m., second shift from 3:00 p.m. - 11:00 p.m., and third shift from 11:00 p.m. - 7:00 a.m. Surveyor observed the following staff who worked sometime during second and third shifts on 07/17/2024: - Caregiver D: 3 hours worked between 3:00 p.m. - 11:00 p.m. and 0.3 hours from 11:00 p.m. until 7:00 a.m. on 07/18/2024 (specific times worked not documented) - Caregiver F: 0.3 hours worked between 3:00 p.m. - 11:00 p.m. (specific time worked not documented) - Former Caregiver T: 4.5 hours from 3:00 p.m. - 11:00 p.m. (specific time worked not documented) - Caregiver U: 7.5 hours from 11:00 p.m. - 7:00 a.m. on 07/18/2024 (specific time worked not documented) - Caregiver R: 0.3 hours from 7:00 a.m. - 3:00 p.m. and 3.3 hours from 3:00 p.m. - 11:00 p.m. (specific times worked not documented) At approximately 2:30 p.m. Surveyor interviewed House Manager B about the staff schedule. House Manager B reported s/he saw staff on the schedule for the evening of 07/17/2024 that did not actually work. House Manager B confirmed that the schedule didn't clarify the times that partial shift hours were worked, such as Caregiver R working 3.3 hours from 3:00 p.m. - 11:00 p.m. Surveyor then requested the timecards for staff that worked during second and	N 399		

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third shift times on 07/17/2024 in order to specifically see which staff worked during which times.

From the timecards provided by House Manager B, the following staff were shown as working during the second and third shifts of 07/17/2024:

- Caregiver F: 7:01 a.m. - 3:13 p.m. (corroborated with the 0.3 hours worked during second shift as shown on the staff schedule)
- Former Caregiver T: 2:59 p.m. - 7:30 p.m. (corroborated with the 4.5 hours worked during second shift as shown on the staff schedule)
- Caregiver R: 3:07 p.m. - 6:18 p.m. (corroborated with the approximate 3.3 hours worked during second shift as shown on the staff schedule)
- Caregiver U: 11:25 p.m. - 7:06 a.m. on 07/18/2024 (corroborated with the 7.5 hours worked during third shift as shown on the staff schedule)

There was no timecard information for Caregiver D. At approximately 2:40 p.m., House Manager B reported s/he could not find any timecard for Caregiver D that evening and reported s/he didn't think s/he worked then. House Manager B reported that s/he thought Caregiver D showed up on the schedule because s/he came to say his/her goodbyes to Resident 8 upon him/her passing that evening.

Between the staff schedule and timecard data, no one was shown as working at the facility from 7:30 p.m. until 11:25 p.m.

At approximately 8:18 p.m., Surveyors interviewed House Manager B. House Manager B reported that on the night of 07/17/2024 s/he thought maybe staff from other buildings

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N 399	Continued From page 101 (separately licensed CBRFs) floated to the provider and helped with second shift until third shift came on. House Manager B acknowledged that the schedule was not maintained to correctly reflect who worked on the evening of 07/17/2024. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws N0397 DHS 83.36(1)(b) Qualified Staff in Charge, on Duty, and Awake	N 399		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 8, who was prescribed 2 scheduled psychotropic medications, was reassessed by a pharmacist, practitioner, or registered nurse at least quarterly for the desired responses and possible medication side effects and that these assessments were documented in his/her record.	N 407		

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N 407	Continued From page 102 This requirement is being cited for the second time. See Statement of Deficiency (SOD) UDWF11, issued 02/19/2021. The findings include: On 08/29/2024, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider on 11/28/2023 with diagnoses including dementia and bipolar disorder. Resident 8 resided with the provider until s/he passed away on 07/17/2024. Resident 8 was documented on his/her face sheet as having an activated power of attorney (POA) for healthcare. Resident 8's scheduled psychotropic medications included the following: - Aripiprazole 5 mg tablets, with a start date of 01/02/2024 (active until his/her death) and instructions to, "Take 2 tablets (1000 mg) by mouth every night at bedtime" - Donepezil 10 mg tablets, with a start date of 12/26/2023 (active until his/her death) and instructions to, "Take 1 tablet by mouth every night at bedtime" Surveyor did not observe any psychotropic medication reviews for the above medications in Resident 8's record. At approximately 5:16 p.m., Surveyor interviewed House Manager B. House Manager B confirmed s/he could not find any psychotropic medication reviews for Resident 8 in his/her record. House Manager B reported s/he thought Facility Nurse N may have completed these and so s/he sent him/her a message to ask about them. House Manager B reported s/he was otherwise unfamiliar with what psychotropic medication reviews were.	N 407		

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N 407	Continued From page 103 At approximately 8:18 p.m., Surveyor interviewed House Manager B again. House Manager B confirmed s/he did not have any psychotropic medication reviews for Resident 8. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws	N 407		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 9's individual service plan (ISP) included the rationale for use and detailed description of behaviors	N 408		

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indicating the need for his/her as needed (PRN) lorazepam, or that the administrator or qualified designee monitored him/her at least monthly for the inappropriate use of his/her PRN lorazepam for 2 of 2 months of use.

The findings include:

On 08/29/2024, Surveyor reviewed Resident 9's record. Resident 9 was admitted to the provider on 03/26/2020 with diagnoses including mild cognitive impairment and major depressive disorder. Resident 9 was documented as receiving hospice services since 05/29/2024. Resident 9 was documented as having an activated POA for healthcare. Resident 9's PRN psychotropic medications included the following:

- Lorazepam 0.5 mg tablets, with a start date of 05/31/2024 and instructions to, "Take 1 tablet by mouth every hour as needed for anxiety, agitation, restlessness."

On 08/29/2024, Surveyor reviewed Resident 9's medication administration records (MARs) from 06/01/2024 - 08/29/2024 and observed the following:

- June 2024: 2 administrations of his/her lorazepam
- July 2024: 3 administrations of his/her lorazepam
- August 2024: 6 administrations of his/her lorazepam

Surveyor reviewed Resident 9's individual service plan (ISP), dated 08/29/2024 (day it was last reviewed was not documented). There was no information in his/her ISP regarding his/her PRN lorazepam use or any adverse behaviors s/he

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N 408	Continued From page 105 was known to demonstrate. Surveyor did not observe any psychotropic medication reviews for Resident 9's lorazepam in his/her record. At approximately 5:16 p.m., Surveyor interviewed House Manager B. House Manager B confirmed s/he could not find any psychotropic medication reviews for Resident 9 in his/her record. House Manager B reported s/he thought Facility Nurse N may have completed these and so s/he sent him/her a message to ask about them. House Manager B reported s/he was otherwise unfamiliar with what psychotropic medication reviews were. At approximately 8:18 p.m., Surveyor interviewed House Manager B again. House Manager B confirmed s/he did not have any psychotropic medication reviews for Resident 9. House Manager B acknowledged Surveyor's concern that a detailed description of Resident 9's behaviors warranting the administration of his/her lorazepam were not documented in his/her ISP but said nothing further. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws	N 408		
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	N 409		

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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:
Based on record review and interview, the provider did not ensure a proof-of-use record for Resident 9's morphine, a schedule II drug, was maintained and audited on a daily basis.

There was no evidence that staff audited Resident 9's as needed (PRN) morphine on 48 days between 06/01/2024 - 08/29/2024.

A deduction of Resident 9's PRN morphine was made on 06/25/2024 in his/her controlled substance count log but was unaccounted for in the record, his/her observation notes, or his/her medication administration record (MAR).

Staff inconsistently applied different count systems to account for Resident 9's morphine in his/her controlled substance count logs - at times using whole numbers to correlate with deductions (e.g. deduction of "1" correlating with the administration of 1 syringe) and at times using half-number increments to correlate with deductions (e.g. deduction of "0.5" correlating with the administration of 1 syringe). House Manager B was unable to explain these discrepancies or account for what the on-hand quantity should have been.

Resident 9's scheduled morphine began on 08/28/2024 (day before the survey) and was

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maintained as its own count within the provider's controlled substance count log. The first deduction at 3:47 p.m. that day brought the supply into the negative number values, which continued up to when House Manager B observed the computer count with Surveyor at 6:50 p.m. on 08/29/2024, where the on-hand quantity was "-1.5." House Manager B was unable to account for how the on-hand quantity fell in the negative number range.

On 08/29/2024 at 5:22 p.m., during the survey, a deduction of Resident 9's morphine was entered on the controlled substance log by Caregiver O. However, based on Surveyors' observations of Caregiver O leaving the building at the end of his/her shift at approximately 3:00 p.m. (approximately 2.5 hours earlier) and review of Resident 9's MAR, Caregiver O did not administer morphine to Resident 9.

While auditing Resident 9's morphine supply with Caregiver K and House Manager B, House Manager B was observed to edit the on-hand supply of Resident 9's morphine (which was "-1.5" prior to the audit) in the log to the number of syringes counted by Surveyor and Caregiver K. House Manager B was unable to account for how the count system was previously conducted or what quantity should have been on hand, reporting that s/he wanted the count in the log to match what Surveyor and Caregiver K counted. Upon further independent review of the count log, Surveyor observed that the count conducted earlier was of Resident 9's as needed (PRN) morphine, but Caregiver K had edited the count of his/her scheduled morphine, which was maintained as a separate count inventory log. This edit caused both Resident 9's PRN and scheduled morphine count logs to both be

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inaccurate.

Twenty syringes of PRN morphine for Resident 9 were delivered to the provider on 08/28/2024, correlated with the bag label observed on site by Surveyor on 08/29/2024. However, no corroborating additions of morphine were added to Resident 9's PRN morphine count log. The PRN morphine supply observed on hand by Surveyor (18 syringes) did not correlate with what was documented as Resident 9's most recent PRN morphine count ("2" - no documentation or explanation to clarify whether this meant 2 syringes, if 1 syringe = count of 1, or 4 syringes, if 1 syringe = count of 0.5). In either count system, the count log quantity did not match what was observed on hand by Surveyor, House Manager B, and Caregiver K.

With all the above inconsistencies, Surveyor was unable to verify whether quantities of morphine observed by Surveyor on site were what was supposed to be on hand.

The findings include:

On 08/29/2024, at approximately 6:50 p.m., Surveyor, along with House Manager B and Caregiver K, observed Resident 9's medications located within the controlled substances locked box within the medication cart. Surveyor observed 1 bag of PRN morphine syringes in the box, prescribed to Resident 9. The pharmacy label on the bag documented that the bag contained "Morphine 100 mg/5 mL solution", dispensed on 08/28/2024, with instructions to, "Take 0.5 mL (10 mg) by mouth every hour as needed for severe pain / shortness of breath ...*prefilled syringes*" A handwritten date of "08/28/2024" was on the sticker indicating the date it was opened. A

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handwritten note in marker on the bag documented: "(#20 [pre-filled syringes] = 10 mL."

House Manager B and Caregiver K reported that counts were typically conducted with each shift change. In counting the number of syringes in the bag, Surveyor and Caregiver K both counted 18 total syringes. House Manager B observed the count taking place. Caregiver K confirmed that there was no other medication cart for the facility. Both Caregiver K and House Manager B confirmed they were unaware of any other morphine syringes for Resident 9. Surveyor asked what the count for Resident 9's syringes was in the provider's schedule II count record. House Manager B pulled up the provider's controlled substance count log from the facility laptop, located on top of the medication cart. Under "Quantity On Hand", the count was shown as "-1.5." House Manager B reported s/he didn't know why the morphine count showed as being within negative number values and could not explain how counts, utilizing decimal numbers, were being conducted by staff. House Manager B reported s/he thought maintaining the count as a whole number count of syringes would make more sense. Surveyor observed on the computer screen that the last 3 counts in the log were as follows:

- 08/28/2024 (3:47 p.m.): Subtraction of "0.5" quantity by Caregiver F, resulting in a new total of "-0.5"
- 08/28/2024 (8:35 p.m.): Subtraction of "0.5" quantity by Caregiver F, resulting in a new total of "-1"
- 08/29/2024 (5:22 p.m.): Subtraction of "0.5" quantity by Caregiver O, resulting in a new total of "-1.5"

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Surveyor observed the entry by Caregiver O, who documented on the controlled substance log administering "0.5" morphine earlier that evening at 5:22 p.m., directly conflicted with Surveyors' observations' that s/he left the facility at the end of his/her shift at approximately 3:00 p.m. Surveyor observed that it also directly conflicted with Surveyors' observations of both medication passes that day conducted by Caregiver O (morning at approximately 10:00 a.m. and lunchtime at approximately 12:15 p.m.) as well as the August MAR for Resident 9, reviewed on 08/29/2024, which documented that Caregiver O did not document administering any morphine that day during his/her shift. From the time that Caregiver O left at approximately 3:00 p.m., Surveyors were in view of all common areas and did not see him/her return at any point after the end of his/her shift.

While interviewing House Manager B at the medication cart regarding Resident 9's morphine, Surveyor observed House Manager B type the morphine count that was just completed by Surveyor and Caregiver K as a quantity of 18, coinciding with what Surveyor and Caregiver K counted. Surveyor asked House Manager B if this would still be an issue since 18 only reflected what was counted that day and did not account for what was delivered from the pharmacy the previous day (20 syringes), the unspecified current decimal number system that staff were using to count Resident 9's syringes, or the fact that the quantity on hand (-1.5) was already in the negative number range. House Manager B nodded but said s/he still wanted to enter 18 because s/he didn't want the count to be off and wanted it to reflect the current number of syringes on hand. Surveyor observed that House Manager B having entered 18 as the on-hand syringe

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quantity resulted in a new on-hand total of 16.5 (-1.5 + 18 = 16.5), which was still not accurate as to what was counted by Surveyor and Caregiver K. Surveyor then requested for House Manager B to provide historic morphine counts for Resident 9 from 06/01/2024 - 08/29/2024.

On 08/29/2024 Surveyor reviewed Resident 9's August MAR, which contained Resident 9's prescription information. Resident 9 had a prescription for scheduled morphine 20 mg/mL solution, with an order start date of 08/28/2024 and instructions to, "Take 0.5 mL by mouth every 4 hours for pain or shortness of breath." Resident 9 also had a prescription for as PRN morphine, at the same concentration, active as of 06/01/2024 and containing instructions to, "Take 0.5 mL (10 mg) by mouth every hour as needed for severe pain, shortness of breath." Surveyor noted that the PRN morphine was what was observed earlier in the medication cart.

On 08/29/2024, Surveyor reviewed the controlled substance count log for Resident 9 from 06/01/2024 - 08/29/2024, provided by House Manager B. In comparing the prescription (Rx) numbers listed on the computer-generated logs with the Rx numbers listed in Resident 9's prescriptions, Surveyor confirmed which morphine counts were included as part of his/her scheduled supply and which counts were included as part of his/her PRN supply, which appeared to be maintained as separate counts within the logs. Surveyor observed the following:

1) Scheduled morphine (order starting on 08/28/2024)
- No initial starting number of the morphine supply was entered
- Quantity totals and decreases matched what

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Surveyor observed on the computer screen earlier for log entries from 08/28/2024 at 3:47 p.m. (first entry) to 08/29/2024 at 5:22 p.m. (all documented above)
- On 08/29/2024 at 6:45 p.m., House Manager B added a quantity "18" which resulted in a total of 16.5 (coinciding with Surveyor's above observations).
- On 08/29/2024 at 6:46 p.m., House Manager B added a quantity of "2" which resulted in a total of 18.5
- On 08/29/2024 at 6:47 p.m., House Manager B subtracted a quantity of "0.5" which resulted in a total of 18

Surveyor observed that House Manager B's edits to the morphine quantity that evening, which were made during and after Surveyor's observation of the morphine supply, were made in Resident 9's scheduled morphine count log, which was not the same morphine count log maintained for his/her PRN morphine supply and did not match with the supply that was observed and counted earlier that evening by Surveyor, House Manager B, and Caregiver K (which was Resident 9's PRN morphine). Surveyor observed that any count for Resident 9's scheduled morphine supply, though not observed by Surveyor in the medication cart, would thus be inaccurate.

2) PRN morphine (active as of 06/01/2024)
- No counts on 48 days, including: 06/04/2024, 06/06/2024, 06/11/2024, 06/13/2024, 06/17/2024, 06/18/2024, 06/20/2024, 06/22/2024 through 06/24/2024, 06/29/2024, 06/30/2024, 07/06/2024 through 07/08/2024, 07/11/2024, 07/13/2024, 07/14/2024, 07/16/2024 through 07/23/2024, 07/25/2024, 07/28/2024, 07/30/2024, 08/01/2024, 08/03/2024 through 08/06/2024, 08/10/2024, 08/11/2024, 08/13/2024, 08/14/2024, 08/16/2024

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COTTAGES OF MADISON APPLEWOOD	5565 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
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through 08/19/2024, 08/21/2024 through 08/23/2024, 08/25/2024 through 08/27/2024

In comparing the PRN morphine count log with Resident 9's MARs from June - August 2024 as well as his/her observation notes for the same timeframe, Surveyor observed the following discrepancies:

- Deduction of "0.5" made by House Manager B on 06/25/2024 at 8:24 a.m. No corresponding entry on the MAR documented that Resident 9 was administered morphine on or around 06/25/2024. No observation note entry on or around 06/25/2024 accounted for this deduction either.

- Deduction of "1" and another deduction of "1" made by Caregiver AA on 12:20 a.m. and 1:24 a.m., respectively. While these times corresponded on the MAR with 2 syringe administrations of Resident 9's morphine, they did not correlate with the count system in the log that staff had used to track Resident 9's morphine, which was in half-number increments, such as on 06/21/2024 where Caregiver D deducted "0.5" on the log which correlated with administration of 1 morphine syringe as documented on Resident 9's MAR. They also did not correlate with House Manager B's deduction of 0.5 on 06/25/2024 (as documented above).

On 09/05/2024, at approximately 3:13 p.m., Surveyor interviewed Director of Clinical Services GG, from Resident 9's hospice agency. Director of Clinical Services GG confirmed that 20 syringes of Resident 9's PRN morphine was delivered on 08/28/2024. Surveyor observed that this correlated with the same bag of PRN morphine that was observed back on 08/29/2024

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N 409	Continued From page 114 in the medication cart. Upon reviewing the provider's controlled substance count log for Resident 9's morphine again (which showed counts as recent as 6:47 p.m. on 08/29/2024), Surveyor did not observe any additions to Resident 9's PRN morphine count inventory that correlated with the delivery of the syringes. As such, Surveyor was not able to reconcile the on-hand quantity of morphine syringes observed on 08/29/2024 (18 syringes) with the on-hand quantity last recorded in his/her PRN inventory ("2" - unclear if this referenced 2 syringes, if 1 syringe = count of 1, or 4 syringes, if 1 syringe = count of 0.5). Surveyor observed that based on the count log quantities, deductions that did not correlate with MAR morphine administrations, and House Manager B's inability to explain the provider's count system, there was no way to verify that the quantity of morphine observed on 08/29/2024 was what was supposed to have been on hand. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws N0432 DHS 83.38(1)(h) Medication Administration	N 409		
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	N 415		

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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 that at the time of medication administration for 2 of 2 residents reviewed staff initialed off on their medication administration records (MARs).

Resident 8's MARs from 06/01/2024 - 07/17/2024 contained 88 blank entries across 8 days.

Resident 9's MARs from 06/01/2024 - 08/29/2024 contained 132 blank entries across 22 days.

The findings include:

Example 1 - Resident 8

On 08/29/2024, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider on 11/28/2023 with diagnoses including dementia and congestive heart failure, vitamin B12 deficiency, and atrial fibrillation. Resident 8 resided with the provider until s/he passed away on 07/17/2024. Surveyor reviewed Resident 8's MARs from 06/01/2024 - 07/17/2024 and observed the following blank entries:

- 06/02/2024: Blank entry for his/her 8:00 a.m. Refresh Tear 0.5% eye drops

- 06/11/2024: Blank entries for 14 of 14 of his/her

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N 415	Continued From page 116 8:00 a.m. medications, which included: Aspirin 81 mg tablet, carvedilol 6.26 mg tablet, digoxin 0.125 mg tablet, furosemide 20 mg tablet, lisinopril 5 mg tablet, Refresh Tear 0.5% eye drops, polyethylene glycol 3350 powder, sertraline 100 mg tablet, spironolactone 25 mg tablet, vitamin B-1 100 mg tablet, vitamin B-12 500 mcg tablet, vitamin D3 25 mcg tablet, memantine HCl 5 mg tablet, and loperamide 2 mg capsule - 06/12/2024: Blank entries for 14 of 14 of his/her 8:00 a.m. medications, which included: Aspirin 81 mg tablet, carvedilol 6.26 mg tablet, digoxin 0.125 mg tablet, furosemide 20 mg tablet, lisinopril 5 mg tablet, Refresh Tear 0.5% eye drops, polyethylene glycol 3350 powder, sertraline 100 mg tablet, spironolactone 25 mg tablet, vitamin B-1 100 mg tablet, vitamin B-12 500 mcg tablet, vitamin D3 25 mcg tablet, memantine HCl 5 mg tablet, and loperamide 2 mg capsule - 06/19/2024: Blank entries for 14 of 14 of his/her 8:00 a.m. medications, which included: Aspirin 81 mg tablet, carvedilol 6.26 mg tablet, digoxin 0.125 mg tablet, furosemide 20 mg tablet, lisinopril 5 mg tablet, Refresh Tear 0.5% eye drops, polyethylene glycol 3350 powder, sertraline 100 mg tablet, spironolactone 25 mg tablet, vitamin B-1 100 mg tablet, vitamin B-12 500 mcg tablet, vitamin D3 25 mcg tablet, memantine HCl 5 mg tablet, and loperamide 2 mg capsule - 06/21/2024: Blank entries for 14 of 14 of his/her 8:00 a.m. medications, which included: Aspirin 81 mg tablet, carvedilol 6.26 mg tablet, digoxin 0.125 mg tablet, furosemide 20 mg tablet, lisinopril 5 mg tablet, Refresh Tear 0.5% eye drops, polyethylene glycol 3350 powder, sertraline 100 mg tablet, spironolactone 25 mg tablet, vitamin B-1 100 mg tablet, vitamin B-12 500 mcg tablet,	N 415		

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vitamin D3 25 mcg tablet, memantine HCl 5 mg tablet, and loperamide 2 mg capsule

- 06/22/2024: Blank entries for 14 of 14 of his/her 8:00 a.m. medications, which included: Aspirin 81 mg tablet, carvedilol 6.26 mg tablet, digoxin 0.125 mg tablet, furosemide 20 mg tablet, lisinopril 5 mg tablet, Refresh Tear 0.5% eye drops, polyethylene glycol 3350 powder, sertraline 100 mg tablet, spironolactone 25 mg tablet, vitamin B-1 100 mg tablet, vitamin B-12 500 mcg tablet, vitamin D3 25 mcg tablet, memantine HCl 5 mg tablet, and loperamide 2 mg capsule

- 07/06/2024: Blank entries for 2 of 2 of his/her 5:00 p.m. medications, which included: Carvedilol 6.25 mg tablet and Refresh Tear 0.5% eye drops

- 07/09/2024: Blank entries for 14 of 14 of his/her 8:00 a.m. medications, which included: Aspirin 81 mg tablet, carvedilol 6.26 mg tablet, digoxin 0.125 mg tablet, furosemide 20 mg tablet, lisinopril 5 mg tablet, Refresh Tear 0.5% eye drops, polyethylene glycol 3350 powder, sertraline 100 mg tablet, spironolactone 25 mg tablet, vitamin B-1 100 mg tablet, vitamin B-12 500 mcg tablet, vitamin D3 25 mcg tablet, memantine HCl 5 mg tablet, and loperamide 2 mg capsule

Example 2 - Resident 9

On 08/29/2024, Surveyor reviewed Resident 9's record. Resident 9 was admitted to the provider on 03/26/2020 with diagnoses including mild cognitive impairment, glaucoma, chest pain, hypertensive heart disease, and major depressive disorder. Surveyor reviewed Resident 9's MARs from 06/01/2024 - 08/29/2024 and observed the following blank entries:

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N 415	Continued From page 118 - 06/03/2024: Blank entries for 2 of his/her 8:00 a.m. medications, which included: brimonidine 0.2% eye drops and dorzolamide-timolol 0.5% eye drops - 06/05/2024: Blank entry for his/her 12:00 a.m. cephalexin 500 mg capsule (an antibiotic that was prescribed to be taken every 6 hours for a 10-day course) - 06/06/2024: Blank entry for his/her 12:00 a.m. cephalexin 500 mg capsule - 06/07/2024: Blank entry for his/her 6:00 p.m. cephalexin 500 mg capsule - 06/08/2024: Blank entry for his/her 12:00 a.m. cephalexin 500 mg capsule - 06/09/2024: Two blank entries for his/her cephalexin 500 mg capsule: 12:00 a.m. and 12:00 p.m. - 06/10/2024: Blank entry for his/her 12:00 a.m. cephalexin 500 mg capsule - 06/11/2024: Blank entries his/her 12:00 a.m. cephalexin 500 mg capsule and 11 of 12 of his/her 8:00 a.m. medications, which included: brimonidine 0.2% eye drops, calcium/D3 600-10 tablet, clopidogrel 75 mg tablet, dorzolamide-timolol 0.5% eye drops, famotidine 20 mg tablet, glucosamine 500 mg capsule, isosorbide mononitrate 30 mg tablet, losartan potassium 100 mg tablet, Senexon 8.6-50 mg tablet, sertraline 25 mg tablet, and multivitamin tablet - 06/12/2024: Blank entry for his/her 8:00 a.m. SMZ / TMP DS 800-160 mg tablet (a combination	N 415		

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of 2 antibiotics that was prescribed to be taken twice a day "for infection" for a 10-day course), 3 blank entries for his/her 12:00 a.m., 6:00 a.m., and 12:00 p.m. cephalexin 500 mg capsules, and blank entries for 12 of 12 of his/her 8:00 a.m. medications, which included: amlodipine 2.5 mg tablet, brimonidine 0.2% eye drops, calcium/D3 600-10 tablet, clopidogrel 75 mg tablet, dorzolamide-timolol 0.5% eye drops, famotidine 20 mg tablet, glucosamine 500 mg capsule, isosorbide mononitrate 30 mg tablet, losartan potassium 100 mg tablet, Senexon 8.6-50 mg tablet, sertraline 25 mg tablet, and multivitamin tablet

- 06/13/2024: Blank entry for his/her 4:00 p.m. brimonidine 0.2% eye drops

- 06/14/2024: Blank entry for his/her 12:00 a.m. cephalexin 500 mg capsule

- 06/19/2024: Blank entry for his/her 8:00 a.m. SMZ / TMP DS 800-160 mg tablet and blank entries for 12 of 12 of his/her 8:00 a.m. medications, which included: amlodipine 2.5 mg tablet, brimonidine 0.2% eye drops, calcium/D3 600-10 tablet, clopidogrel 75 mg tablet, dorzolamide-timolol 0.5% eye drops, famotidine 20 mg tablet, glucosamine 500 mg capsule, isosorbide mononitrate 30 mg tablet, losartan potassium 100 mg tablet, Senexon 8.6-50 mg tablet, sertraline 25 mg tablet, and multivitamin tablet

- 06/21/2024: Blank entry for his/her 8:00 a.m. SMZ / TMP DS 800-160 mg tablet and blank entries for 12 of 12 of his/her 8:00 a.m. medications, which included: amlodipine 2.5 mg tablet, brimonidine 0.2% eye drops, calcium/D3 600-10 tablet, clopidogrel 75 mg tablet,

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dorzolamide-timolol 0.5% eye drops, famotidine 20 mg tablet, glucosamine 500 mg capsule, isosorbide mononitrate 30 mg tablet, losartan potassium 100 mg tablet, Senexon 8.6-50 mg tablet, sertraline 25 mg tablet, and multivitamin tablet

- 06/22/2024: Blank entries for 12 of 12 of his/her 8:00 a.m. medications, which included: amlodipine 2.5 mg tablet, brimonidine 0.2% eye drops, calcium/D3 600-10 tablet, clopidogrel 75 mg tablet, dorzolamide-timolol 0.5% eye drops, famotidine 20 mg tablet, glucosamine 500 mg capsule, isosorbide mononitrate 30 mg tablet, losartan potassium 100 mg tablet, Senexon 8.6-50 mg tablet, sertraline 25 mg tablet, and multivitamin tablet

- 07/02/2024: Two blank entries for his/her 8:00 a.m. brimonidine 0.2% eye drops and 4:00 p.m. Xarelto 15 mg tablet

- 07/06/2024: Two blank entries for his/her 8:00 a.m. brimonidine 0.2% eye drops and 4:00 p.m. Xarelto 15 mg tablet

- 07/09/2024: Blank entries for 12 of 12 of his/her 8:00 a.m. medications, which included: amlodipine 2.5 mg tablet, brimonidine 0.2% eye drops, calcium/D3 600-10 tablet, clopidogrel 75 mg tablet, dorzolamide-timolol 0.5% eye drops, famotidine 20 mg tablet, glucosamine 500 mg capsule, isosorbide mononitrate 30 mg tablet, losartan potassium 100 mg tablet, Senexon 8.6-50 mg tablet, sertraline 25 mg tablet, and multivitamin tablet

- 07/14/2024: Blank entries for 12 of 12 of his/her 8:00 a.m. medications, which included: amlodipine 2.5 mg tablet, brimonidine 0.2% eye

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drops, calcium/D3 600-10 tablet, clopidogrel 75 mg tablet, dorzolamide-timolol 0.5% eye drops, famotidine 20 mg tablet, glucosamine 500 mg capsule, isosorbide mononitrate 30 mg tablet, losartan potassium 100 mg tablet, Senexon 8.6-50 mg tablet, sertraline 25 mg tablet, and multivitamin tablet

- 08/10/2024: Blank entries for 12 of 12 of his/her 8:00 a.m. medications, which included: amlodipine 2.5 mg tablet, brimonidine 0.2% eye drops, calcium/D3 600-10 tablet, clopidogrel 75 mg tablet, dorzolamide-timolol 0.5% eye drops, famotidine 20 mg tablet, glucosamine 500 mg capsule, isosorbide mononitrate 30 mg tablet, losartan potassium 100 mg tablet, Senexon 8.6-50 mg tablet, sertraline 25 mg tablet, and multivitamin tablet

- 08/12/2024: Blank entries for 12 of 12 of his/her 8:00 a.m. medications, which included: amlodipine 2.5 mg tablet, brimonidine 0.2% eye drops, calcium/D3 600-10 tablet, clopidogrel 75 mg tablet, dorzolamide-timolol 0.5% eye drops, famotidine 20 mg tablet, glucosamine 500 mg capsule, isosorbide mononitrate 30 mg tablet, losartan potassium 100 mg tablet, Senexon 8.6-50 mg tablet, sertraline 25 mg tablet, and multivitamin tablet

- 08/26/2024: Blank entry for his/her 8:00 a.m. multivitamin tablet

- 08/28/2024: Blank entries for 2 of his/her 8:00 a.m. medications, which included: glucosamine 500 mg capsule and isosorbide mononitrate 30 mg tablet

At approximately 8:18 p.m., Surveyor interviewed House Manager B. House Manager B

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N 415	Continued From page 122 acknowledged Surveyor's concerns regarding MARs with blank entries but said nothing further. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws	N 415		
{N 425}	83.38(1)(a) Personal care. 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: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 8, Resident 9, and Resident 11 were provided with personal care services adequate to meet their individual needs. Resident 9 was not provided with personal care services related toileting and/or incontinence care.	{N 425}		

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Resident 11 was not provided with personal care services related to daily assistance with dressing/application of Resident 11's prescribed compression "socks."

Resident 8 was not provided with personal care services related to shaving, nail care, incontinence management, and fall mat use.

This requirement is being cited for the second time. See Statement of Deficiency (SOD) OCCY11, issued on 06/17/2024.

The findings include:

Definitions:
DHS 83.02(37) "Personal care" means assistance with activities of daily living, but does not include nursing care.
DHS 83.02(3) "Activities of daily living" means bathing, eating, oral hygiene, dressing, toileting and incontinence care, mobility, and transferring from one surface to another such as from a bed to a chair.

On 07/22/2024 and 08/01/2024, the department received allegations including personal care services were not adequate based on each resident's individual need.

Example 1: Resident 9

On 08/29/2024 at 7:35 A.M., Caregiver O told Surveyors s/he was working alone as the only caregiver on duty at the facility and s/he had started his/her shift at 7:00 A.M. Caregiver O said s/he was waiting for the other caregiver to show up for work and no medications had been administered to the residents since Caregiver O arrived on duty. Caregiver O said the other

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caregiver was to be on duty at 7:00 A.M. and was supposed to be administering medications. Caregiver O told Surveyor s/he did not know the name of the caregiver scheduled to work with him/her from 7:00 A.M. until 3:00 P.M.

On 08/29/2024 at 8:20 A.M., Caregiver O told Surveyor Resident 9 declined to come out of his/her bedroom for breakfast on this morning. Caregiver O told Surveyor Resident 9 "just mumbled" when Caregiver O asked Resident 9 if s/he wanted breakfast. Caregiver O told Surveyor Resident 9 remained in bed and Caregiver O had not provided Resident 9 with any cares after Caregiver O started his/her shift.

On 08/29/2024 at 8:30 A.M., Surveyor observed Resident 9 in his/her bedroom on his/her back in bed with both eyes closed.

On 08/29/2024 at 8:48 A.M., Surveyor observed Caregiver P enter the facility from a car parked in the front parking lot. Caregiver P told Surveyor s/he just "came from home" and was scheduled to work until 3:00 P.M.

On 08/29/2024 at 9:55 A.M. until 10:05 A.M., Surveyor observed Caregiver P rocking bath and forth while seated in a chair in the corner of the dining room near the kitchen's serving window. Surveyor observed Resident 7 approach Caregiver P and ask Caregiver P, "Are you feeling okay? You do not look right." Surveyor observed Caregiver P tell Resident 7 s/he was tired because s/he worked late last night. Surveyor observed Caregiver P proceed to hold his/her head with one hand and look down at a phone s/he held in his/her other hand as s/he rocked back and forth in the chair.
At approximately 10:06 A.M. until approximately

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{N 425}	Continued From page 125 10:20 A.M., Surveyor observed Caregiver P stand up from the chair, walk outside to the back patio, sit down in a chair outside, and proceed to look down at his/her phone. On 08/29/2024 between 10:20 A.M. and 11:49 A.M., Surveyor made several observations of Resident 9 remaining in his/her bedroom on his/her back in bed. On 08/29/2024 at 11:28 A.M., Surveyor observed Resident 7 conduct a bingo game with a small group of residents including Resident 5 and Resident 11. During this activity, Surveyor observed Caregiver O sitting in a chair located between the facility's central fireplace and the back patio exit while looking down at a phone held in his/her lap with both hands and Caregiver P standing in the kitchen while leaning on the counter of the kitchen serving window with his/her elbows on the counter. Caregiver P was observed to be holding his/her head with his/her left hand and his/her phone with his/her right hand. Both caregivers were observed to be engaged in looking down at the phones and not engaging with the residents. At 11:31 A.M., the front entrance door bell rang and neither Caregiver O or Caregiver P responded. At 11:34 A.M., Caregiver O stood up from the chair and walked into the facility's living room when Administrator M walked past Caregiver O and walked up to the kitchen counter to retrieve a pair of gloves from a box located on the counter. Caregiver P remained standing and continued to look down at the phone s/he was holding. Administrator M did not interact with either Caregiver O or Caregiver P before walking away from the kitchen serving window. Caregiver P returned from the living room and sat down in the same chair between the fireplace and back patio	{N 425}		

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exit. At 11:35 A.M., Surveyor observed Resident 5 drop several small bingo pieces from the table to the floor and Resident 7 attempted to assist Resident 7 with retrieving the bingo pieces without any response from either Caregiver O or Caregiver P. At 11:38 A.M., Surveyor observed Caregiver P walk from the kitchen to the dining room table, yawn, and stretch without interacting with the residents seated at the table. Caregiver P looked at the television located above the fireplace. At 11:42 A.M., Surveyor observed Caregiver P walk back to the kitchen and look down at the phone located on the kitchen counter. Administrator M again walked by Caregiver O and Caregiver P without interacting with either caregiver. At approximately 11:43 A.M., Surveyor observed Caregiver P open the medication room door, retrieve a purse from the inside of the door, walk back into the dining room and mumble something unintelligible to Caregiver O seated in the chair. At approximately 11:45 A.M., Surveyor observed Caregiver P walk through the dining room, out the front entrance of the facility, and get into a vehicle before driving out of the parking lot.

On 08/29/2024 at 11:49 A.M., Surveyor observed Caregiver O enter Resident 9's room. At approximately 11:55 A.M., Surveyor entered Resident 9's room and observed a pile of bed linens located on the floor near Resident 9's bed. Resident 9 was seated at the edge of the bed with Caregiver O assisting Resident 9 to put on a pair of pants before transferring Resident 9 to a wheelchair. Caregiver O picked up the pile of bed linens, carried them to the laundry room, placed them in the washer, and started the washer. Caregiver O told Surveyor Resident 9's bed linens were wet with urine but Resident 9's incontinence brief was dry so s/he did not provide

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incontinence care to Resident 9. Caregiver O said s/he removed the bed linens from Resident 9's bed to be laundered and helped Resident 9 get dressed. Caregiver O told Surveyor Caregiver P said s/he changed Resident 9's incontinence brief at approximately 9:00 A.M. when Caregiver O was passing resident medications. Caregiver O said Caregiver P did not change Resident 9's wet bed linens at that time and Resident 9 remained in bed. Caregiver O told Surveyor this was the only time Caregiver O assisted Resident 9 on this morning.

On 08/29/2024 at 12:15 P.M., House Manager B told Surveyor s/he was not aware Caregiver P had left the facility at approximately 11:45 A.M. during his/her shift and just before resident meal time. House Manager B told Surveyor s/he was aware of both Caregiver P and Caregiver O "sitting around" with their phones and not interacting with residents.

On 08/29/2024 at 12:25 P.M., approximately 50 minutes after Surveyor observed Caregiver P leave the facility, Surveyor observed Caregiver P enter the facility through the front entrance after parking a vehicle in the facility's parking lot.

On 08/29/2024, Surveyor reviewed Resident 9's record. Resident 9 was admitted to the provider on 03/26/2020 with diagnoses including repeated falls and mild cognitive impairment.
Surveyor reviewed Resident 9's ISP, dated 08/29/2024 (day of the survey), and observed the following:
- Adaptive equipment use of a walker noted
- Under the "Dressing" heading: " ...[Resident 9] is independent with putting on taking of [sic] and fastening up clothing. [Resident 9] may need assistance putting on shoes and socks ..."

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{N 425}	Continued From page 128 - Under the "Grooming" heading: "[Resident 9] requires staff monitoring and/or reminders and cues to complete grooming tasks. [Resident 9] is independent (Washing face, comb hair, shave, use deodorant) [Resident 9] needs set-up and stand by supervision to ensure task is preformed [sic] properly ..." - Under the "Toileting" headings: One section documented that Resident 9 was "independent with toileting" and another section documented that, "Resident requires partial assistance from staff to complete toileting tasks. Will go on own sometimes but needs help changing depends and clothing when needed." - Under the "Ambulation" heading: "At times [Resident 9] is unsteady when ambulating, use gait belt for safety and to prevent falls. Independent with ambulation. [Resident 9] is able to ambulate independently with assistance from a walker. [Resident 9] often needs reminds [sic] to use walker ..." Surveyor observed that the recommendation for staff to use a gait belt for assisting in Resident 9's ambulation directly conflicted with information that Resident 9 was independent for ambulation. - Under the "Transferring" heading: "Independent with transfers. [Resident 9] is able to ambulate and transfer independently with assistance from a walker. [Resident 9] often needs reminds [sic] to use walker." On 08/29/2024 at 12:38 P.M., Surveyor conducted an interview with House Manager B. House Manager B told Surveyor Resident 9 experienced an unwitnessed fall on 08/28/2024 and possibly sustained a hip or pelvic fracture. House Manager B told Surveyor Resident 9 started receiving hospice services approximately one month ago and no x-rays were performed related to Resident 9's fall on 08/28/2024. House	{N 425}		

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Manager B said Resident 9 required full assistance with all personal cares, including incontinence care, and should be transferred to the toilet only if Resident 9 did not express pain during a transfer. House Manager B told Surveyor Resident 9 had been eating without any concerns with his/her appetite. House Manager B said Resident 9 was able to feed self and House Manager B was not aware Resident 9 did not eat breakfast on this day. House Manager B told Surveyor s/he had not updated Resident 9's ISP to reflect recent changes in Resident 9's needs and services.

On 08/29/2024 at 1:01 P.M., Surveyor conducted an interview with Caregiver P. Caregiver P told Surveyor s/he changed Resident 9's incontinence brief at approximately 9:00 A.M. even though Resident 9 was not incontinent at that time. Caregiver P told Surveyor s/he changed Resident 9's brief because it was a "pull-up type" brief. Caregiver P told Surveyor s/he did not transfer Resident 9 out of bed or to the toilet because Resident 9 had pain but Caregiver P was unable to describe Resident 9's symptoms of pain to Surveyor. Caregiver P told Surveyor s/he did not know when Resident 9 was incontinent and did not realize Resident 9's bed linens were wet when s/he assisted Resident 9 at approximately 9:00 A.M. Caregiver P said the only time s/he assisted Resident 9 on this morning was at 9:00 A.M.

On 08/29/2024 at 5:24 P.M., Surveyor conducted an interview with House Manager B. House Manager B told Surveyor Caregiver P did not notify House Manager B or anyone else that s/he was aware of that Caregiver P was going to be late to work at the facility this morning. House Manager B said the day shift started at 7:00 A.M. and that was when Caregiver P should have been

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at the facility. House Manager B said Caregiver P just showed up late without communicating with anyone and it was not acceptable. House Manager B told Surveyor each caregiver has a 2 separate 15 minutes breaks, one before the residents' lunch and one after the residents' lunch, and 1 half hour break per 8 hour shift. House Manager B said the 15 minute breaks were not to be used together or added on to their half hour break unless authorized by House Manager B or another management staff. House Manager B said s/he could tell how long Caregiver P was gone during the residents' lunch because of the external camera facing the parking lot.

Example 2: Resident 11

On 08/29/2024 at 9:08 A.M., Surveyor observed Resident 11 seated in an automatic, scooter-type wheelchair at a dining table. As Surveyor observed Caregiver O administer Resident 11's medications, Surveyor observed Resident 11's bilateral lower legs and ankles were bare and appeared edematous (swollen).

On 08/29/2024 at 12:25 P.M., Surveyor observed Resident 11 seated in an automatic, scooter-type wheelchair at a dining table. Surveyor observed Resident 11's bilateral lower legs and ankles remained bare and edematous.

On 08/29/2024 at 12:38 P.M., Surveyor conducted an interview with House Manager B. House Manager B told Surveyor Resident 11 did experience edema to bilateral lower extremities and Resident 11's edema was to be monitored by caregivers.

On 08/29/2024 at approximately 4:02 P.M.,

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{N 425}	Continued From page 131 Surveyor conducted an interview and review of resident medications and medication administration documentation with Administrator M, including practitioner's orders for Resident 11. Administrator M and Surveyor reviewed Resident 11's August 2024 medication administration record [MAR]. Resident 11's August 2024 MAR included a prescription for "Coverflex Grip 3.4 [a tubular, compression bandage] to be applied to both lower extremities daily * on in the morning and off at bedtime." Resident 11's August 2024 MAR included Caregiver O's documentation of application at "9:31 A.M." Administrator M told Surveyor Resident 11 to be assisted with application/dressing of compression "socks" daily, as ordered. During a discussion about medication administration concerns, including Resident 11's compression "socks" not being applied on 08/29/2024 by Caregiver O, or any other caregiver, Administrator M told Surveyor "this is unacceptable" and caregivers administering resident medications will be trained to ensure practitioner orders/prescriptions are followed. On 08/29/2024 at 8:18 P.M., Surveyors conducted an interview with House Manager B discussing concerns with Resident 9's and Resident 11's personal cares and the observations of caregivers during this onsite visit. House Manager B told Surveyors the facility did not have a current policy regarding caregiver use of phones or electronic devices while on duty, except caregivers were not supposed to use "face time." House Manager B told Surveyor "staffing" was an ongoing challenge and it was "like this everywhere." House Manager B said, "Just how it is."	{N 425}		

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{N 425}	Continued From page 132 Example 3: Resident 8's shaving, nail care, incontinence management, and fall mat use On 08/29/2024/2024, at approximately 5:37 p.m., Surveyor interviewed Caregiver D regarding Resident 8's care needs. Caregiver D reported that throughout Resident 8's admission, s/he required staff assistance for facial shaving, approximately once per week, and nail trimming (both fingernails and toenails), approximately once per month. Caregiver D also reported that Resident 8 was known to have a fall mat throughout his/her admission that staff were to use at night when s/he was in bed to prevent fall-related injuries. Caregiver D reported s/he didn't think staff used it every night and that s/he suspected this because when there were multiple days in between his/her shifts s/he would see the mat folded the same way s/he had folded it, placed in the same location s/he had last placed it. Caregiver D reported that throughout Resident 8's admission s/he was known to be incontinent of both his/her bowel and bladder and had near daily incontinence episodes that required staff assistance for management of incontinence products. Caregiver D reported that s/he had a leave of absence from the provider that had lasted for approximately a couple of months from the end of February until the end of April. Caregiver D reported that when s/he returned to work after this Resident 8 told him/her that no one showered him/her during his/her absence and s/he suspected that no cares (showers, shaving, nail care) were done for Resident 8 during his/her approximate 2-month absence due to his/her appearance. Caregiver D reported s/he observed Resident 8's hair to be greasy, his/her toenails and fingernails to be really long, and bowel movement residue under his/her fingernails.	{N 425}		

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Caregiver D reported that when s/he showered Resident 8 upon his/her return, Resident 8 cried of happiness. Caregiver D also reported that the initial shower s/he assisted Resident 8 with upon his/her return was painful for Resident 8, because s/he was observed to have redness consistent in appearance with a yeast infection in his/her groin and stomach area skin folds. Caregiver D reported that those skin areas smelled really bad and were painful because Resident 8 cried out when s/he attempted to wash those areas. Caregiver D reported s/he was concerned that other staff were not addressing Resident 8's care needs, and that House Manager B had told him/her about an incident where Family Member W, who was Resident 8's activated power of attorney (POA) for healthcare, came to the facility and complained about the lack of cares that Resident 8 was receiving. Caregiver D reported that s/he had told Administrator A about his/her concerns regarding Resident 8's lack of cares and Administrator A told him/her to tell the facility nurse about it.

At approximately 8:18 p.m., Surveyor interviewed House Manager B. House Manager B reported s/he was aware of different care concerns brought up by Family Member W regarding Resident 8's cares. House Manager B reported s/he recalled one occasion shortly after Resident 8's move-in that Family Member W complained to Former Administrator A about staff not changing Resident 8. House Manager B reported s/he was also aware of other concerns raised by Family Member W including Resident 8 frequently being wet, Resident 8's call light having issues, and Resident 8 not participating in activities. House Manager B reported s/he was pretty sure s/he recalled Family Member W being upset about Resident 8's cares and that these concerns were

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discussed during a care conference that included him/her, Former Administrator A, and Resident 8's managed care organization (MCO) team. House Manager B reported s/he did not think any notes were taken by the provider's staff regarding this conference and what was discussed.

On 08/29/2024, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider on 11/28/2023 with diagnoses including dementia and bipolar disorder. Resident 8 resided with the provider until s/he passed away on 07/17/2024. Resident 8 was documented on his/her face sheet as having an activated power of attorney (POA) for healthcare. In reviewing Resident 8's individual service plan (ISP), dated 08/29/2024 (day of the survey), Surveyor did not observe any information regarding Resident 8's fall mat use, shaving needs, nail care needs, and incontinence with required assistance to manage incontinence products.

On 09/04/2024, at approximately 12:01 p.m., Surveyor interviewed Nurse Case Manager DD. Nurse Case Manager DD reported s/he had been part of Resident 8's MCO care team for the past 3 years. Nurse Case Manager DD reported that Family Member W frequently brought up concerns that staff were not following through with Resident 8's cares, such as toileting and grooming, and would send pictures as evidence. Nurse Case Manager DD reported that when this happened both him/her and the other case manager from Resident 8's MCO team, Case Manager EE, would set up care conferences/meetings with the provider's staff to discuss the concerns. Nurse Case Manager DD reported that Former Administrator A and House Manager B were apart of some of these meetings. Nurse Case Manager DD reported that

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approximately 2-3 in-person meetings occurred during Resident 8's admission to discuss care concerns and several e-mails between the MCO team and the provider's staff were exchanged as well. Nurse Case Manager DD reported that Former Administrator A and House Manager B would typically reply to the concerns stating they were trying to address them and would promise that the issues would be resolved. Nurse Case Manager DD reported that the issues were never resolved, however, and as a result, Resident 8's MCO team was actively trying to transfer him/her to a new facility.

During the interview, Nurse Case Manager DD reported that during the MCO's team visits for the in-person meetings, s/he could tell that Resident 8 was not being shaved or assisted with grooming due to his/her appearance. Nurse Case Manager DD reported that Resident 8 was never clean and that s/he didn't think staff were helping to appropriately toilet him/her or manage his/her incontinence. Nurse Case Manager DD also reported s/he had concerns that staff were not compliant with fall mat use for Resident 8, which was recommended to be used at night due to him/her experiencing falls out of bed. Nurse Case Manager DD reported that staff admitted to him/her they were not using it due to being concerned that Resident 8 would trip over it. Nurse Case Manager DD reported that in response, s/he had recommended for staff to frequently check on him/her at night to see if s/he was trying to get him/herself up out of bed. Nurse Case Manager DD reported that these concerns persisted throughout Resident 8's admission and were still not resolved by the time Resident 8 had passed away.

On 09/04/2024, Surveyor reviewed e-mails

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provided by Nurse Case Manager DD showing correspondence between Resident 8's managed care organization (MCO) representatives, Nurse Case Manager DD and Case Manager EE, and various provider staff, related to Resident 8's needs. Surveyor observed the following:

1) An e-mail sent by Case Manager EE to Former Administrator A, Nurse Case Manager DD, and Former Facility Registered Nurse (RN) FF on 11/29/2023 at 10:25 a.m. (one day after Resident 8's admission), documented, " ...[Resident 8] tends to present as more capable that [sic] what [s/he] is, so I just want to ensure that [his/her] needs are understood. Just a couple things to note - [Resident 8] needs assistance with cutting [his/her] fingernails, weekly or bi-weekly. [S/he] also needs more assistance with toileting that [sic] [s/he] lets on. [S/he] needs to have frequent checks to ensure [s/he] is clean and dry. [S/he] has some issues with diarrhea and needs help making sure [s/he] is clean ..." The reply e-mail sent by Former Administrator A, was, " ...Thanks for reaching out ..." Subsequent e-mails in this thread identified a proposed care conference for 12/12/2023 to discuss Resident 8's needs and supports as well as a confirmation that a care conference was to take place on that day.

2) An e-mail sent by Nurse Case Manager DD to Former Administrator A, Case Manager EE, Former Facility RN FF, Former Facility Licensed Practical Nurse (LPN) S, and House Manager B on 01/12/2024 at 3:33 p.m. documented, " ... [Family Member W] is still concerned [Resident 8]'s showers are not getting done and also the fall mat has not been out when [Resident 8] has been there while [Resident 8] has been in bed ..." The reply by Administrator A documented, "I have seen the fall mat being used, showers are getting

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF MADISON APPLEWOOD	5565 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
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done and documented as well."

3) An e-mail sent by Nurse Case Manager DD to Former Administrator A, Case Manager EE, Former Facility RN FF, Former Facility LPN S, House Manager B, and Former Caregiver II on 03/19/2024 at 9:08 a.m. The e-mail documented, "[Family Member W] states [Resident 8] does not have any more incontinence products. When [Resident 8] is about to run out of incontinence products the facility is responsible for calling [company] to order more ...I called today to make sure [s/he] can get some soon ...Also wanted to follow up about [Resident 8]'s showers and [his/her] shaving. [Family Member W] does not think these two things are happening. [Family Member W] stated [s/he] has shaved [Resident 8] the last two weeks. Can we make sure [Resident 8] is getting showered and shaved?" The reply by Administrator A documented, "I will keep a look out for the supplies. I will double check on the showers and shaving." No other follow up was e-mailed by the provider's staff, as evidenced by the next e-mail exchange in the thread being the e-mail exchange below.

4) An e-mail sent by Case Manager EE to the same staff identified above on 04/12/2024 at 9:30 a.m., which documented, " ...What can we do to ensure that [Resident 8] is getting [his/her] shower and shaved? [Resident 8] likes to be clean shaven." The reply by Administrator A documented, " ...I will have [House Manager B] and [Former Caregiver II] make sure being shaved EVERY shower day in [his/her] daily tasks."

5) An e-mail sent by Case Manager EE to Former Administrator A, House Manager B, Former Facility LPN S, and Former Caregiver II on

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04/23/2024 at 8:26 a.m. The e-mail documented, " ...[Former Administrator A] - I know you have spoken with [Family Member W] recently and [s/he] has expressed ongoing concerns regarding [Resident 8]'s care. It appears to be all basic care needs that continue to just not happen ..."

On 09/04/2024, at approximately 4:30 p.m., Surveyor interviewed Family Member W. Family Member W reported that during Resident 8's admission there were 3 or 4 care meetings to discuss the various care concerns s/he had. Family Member W reported that the same concerns were brought up and discussed every meeting. Family Member W reported that Former Administrator A participated in at least 2 of the meetings and House Manager B participated in some of them, too. Family Member W reported that Resident 8 had complained about the lack of cares s/he received "all the time" throughout his/her admission. Family Member W reported that Resident 8 was always known to maintain a clean-shaven face throughout his/her life and always shaved him/herself when s/he was able to. Family Member W reported that after Resident 8 admitted to the provider s/he was frequently observed with facial whiskers grown out due to staff not shaving him/her, which bothered him/her. Family Member W also reported that s/he had provided a nail grooming kit when Resident 8 was admitted to the provider for staff to conduct nail trimming and care, however, throughout Resident 8's admission his/her fingernails and toenails were grown out and the area underneath his/her fingernails was always dirty. Family Member W reported that later during Resident 8's admission Resident 8's toenails had gotten so long that Former Administrator A told him/her that s/he had to be taken to a podiatrist for nail trimming. Family Member W reported that

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{N 425}	Continued From page 139 as a result, sometime around late June or July 2024 another family member took Resident 8 to the podiatrist where s/he finally got his/her toenails trimmed. Family Member W reported being frustrated with the lack of shaving and nail care because upon Resident 8's admission Former Administrator A had told him/her that these cares would be completed by staff as part of Resident 8's basic care needs. Family Member W reported that the lack of shaving and nail cares were brought up at all care conferences but "were never resolved" and persisted up until the time that Resident 8 passed away. During the interview, Family Member W also reported concerns that staff were not consistently using the fall mat Resident 8 had. Family Member W reported that Resident 8 typically used a fall mat placed next to his/her bed at night in order to prevent injuries since s/he was known to fall out of bed on multiple occasions. Family Member W reported that s/he discussed Resident 8's fall mat use during the first care conference they had. Family Member W reported that there were multiple occasions when s/he would come to the facility to visit Resident 8, who was still in bed, and the fall mat would be folded up under his/her bed. Family Member W reported that earlier in Resident 8's admission there was a night during which s/he had a fall that resulted in a facial laceration that required sutures. Family Member W reported s/he suspected the fall mat was not used that evening due to the nature of Resident 8's laceration. Family Member W reported the morning after this fall s/he went to visit Resident 8. Family Member W reported that Resident 8 was still in bed and the fall mat was under his/her bed. Family Member W reported that the inconsistent fall mat use was brought up at Resident 8's care conferences but the issue was	{N 425}		

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never resolved and persisted up until the time Resident 8 passed away.

During the interview, Family Member W also reported concerns that staff were not assisting Resident 8 with his/her incontinence cares and toileting him/her every 2 hours. Family Member W reported that Resident 8 was known to be incontinent for years prior to his/her admission but it had gotten worse prior to him/her passing away in July 2024. Family Member W reported there were several times during his/her visits with Resident 8 that s/he didn't think 2-hour toileting was occurring based on how soiled Resident 8 appeared - with some feces and urine having soaked through his/her clothes and on his/her legs. Family Member W reported that in a typical week s/he observed Resident 8 like this on 3 or 4 occasions. Family Member W reported that s/he had to change Resident 8 him/herself during visits or specifically find a staff member to request that s/he be changed. Family Member W reported that the lack of incontinence cares and toileting was brought up at Resident 8's care conferences but the issue was never resolved and persisted up until the time Resident 8 passed away.

On 09/04/2024, Surveyor reviewed screenshots of text message exchanges between Family Member W and Former Administrator A, provided by Family Member W, and observed the following regarding the care concerns raised for Resident 8:

1) One series of exchanges, starting on 12/23/2024 at 8:57 a.m. show Family Member W expressing concern that Resident 8's fall mat was not being used. The reply by Former Administrator A that day was, " ...I wasn't aware

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{N 425}	Continued From page 141 [s/he] had a fall mat ..." 2) One text conversation, starting on 02/17/2024 at 1:13 p.m. Family Member W texted, "Hi [Former Administrator A] I just got back from my vacation and came to see [Resident 8] on our care plan meeting [s/he]'s supposed to be cleanly shaven is not shaven for an over a week!!!!! And [his/her] diaper is full of piss and [his/her] bed is wet as well, what's going on [Former Administrator A]?" After this text, Family Member W then sent a picture of Resident 8 in which s/he is observed to have grown-out facial hair on his/her upper lip, chin, and jawline. No follow up response was sent by Former Administrator A. 3) One series of exchanges, starting on 04/18/2024 at 6:26 p.m. Family Member W texted, "Hi [Former Administrator A], sorry to bother you so can I have someone clip [Resident 8]'s toenails and [his/her] fingernails? They're really long looks like they have not been done for a while. I would greatly appreciate that. Thank you." The reply sent that day from Former Administrator A was, "I apologize. I'll have them done." The next day, 04/19/2024, at 3:14 p.m., Family Member W texted, "Hi [Former Administrator A], sorry to bother you again. I know you said you would have someone take care of [Resident 8]'s fingernails and toenails. I went there again just now nothing's been done ...I'm gonna call [Case Manager EE] and see if we can get another Care meeting planned or scheduled because I don't think that things are being taken care of the way they should be, let me know if you get any questions. Thank you." The reply sent that day from Former Administrator A was, "I agree about having another care meeting."	{N 425}		

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{N 425}	Continued From page 142 The next text, sent by Family Member W on 04/22/2024 at 5:53 p.m., documented, "Hi [Former Administrator A, sorry to bother you again but today is Monday. I just stopped by [Resident 8]'s and from our last message I sent that [his/her] fingernails and toenails were not clipped yet. Today is Monday and they're still not done yet. Hopefully you can clip them or have somebody clip them before we have this Care meeting. I would appreciate it and thank you so very much for understanding." The next text, sent by Family Member W on 04/27/2024 at 5:44 p.m., documented, "Hi [Former Administrator A], sorry to bother you again but this seems to be an ongoing thing with us. [Resident 8]'s fingernails and toenails are still not clipped. I've got your text messages saying you have somebody right on it ...this is getting beyond bearable so I don't know what it's going to take to have you take care of [Resident 8] the way [s/he] should be and the money [s/he] is paying for to be taken care of the way should be is not as unacceptable [Former Administrator A] ...Had enough of begging you to do what you're supposed to do for [Resident 8] and apparently other residence [sic] that are not being taken care of!!!" The reply that day sent by Former Administrator A was, "The podiatrist doesn't come until june. I'd make an appointment to get them cut prior to that. If they are thick and longer, a podiatrist needs to cut them. [House Manager B] has [his/her] office in apple and is your go to person. I think I said this before. We have had meetings and training with staff and are observing them doing their tasks. I'm sorry you feel this way. I really am." Family Member W's next reply was, "We have Care meetings about this and every Care meeting that we have is that they're going to	{N 425}		

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{N 425}	Continued From page 143 clip [his/her] nails and [his/her] toenails and shave [him/her] and it still doesn't get done. I don't know what you're trying to tell me but it's unacceptable [Former Administrator A]. so [sic] the only thing I'm going to do for now is make sure that it gets done I'll make the phone calls I need to make and there's no need to be sorry I'm sorry that you can't do what you say you're going to do that's what [sic] sorry about it. Unacceptable [Former Administrator A] ...I apologize, but I've asked you nicely numerous times. I've taken pictures. I've sent out an e-mail to [his/her] Care team for [MCO organization] again ...what's really going on [Former Administrator A]? Why are [Resident 8]'s fingernails toenails and not being shaving like the care plan calls for we've had this meeting numerous times [Former Administrator A] and it doesn't ever seem to be taken care of. We'll find out when we have this meeting on Tuesday of where we go next." Former Administrator A's next reply was, "I've written people up, fired people and retrained people. It's aggravating. I'm also in daily contact with the head people of [MCO] provider concerns department." Family Member W's next reply was, " ...I'm done begging for [Resident 8] to be taken care of the way [s/he] should be taken care of and the way we are paying you to take care of [him/her]." Former Administrator A's next reply was, "I'm trying my best. [House Manager B] is trying [his/her] best ...If you're not happy with our services you are welcome to move [Resident 8] out. You're not obligated to stay." 4) One text from Former Administrator A, sent on 04/30/2024 at 5:54 p.m.: "I want to apologize for everything and I'd like to have a chance to work through things ...I really am trying to better things, but when you have uncompliant staff it definitely makes things more challenging."	{N 425}		

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{N 425}	Continued From page 144 On 09/06/2024, at approximately 11:08 a.m., Surveyor interviewed Case Manager EE. Case Manager EE reported that throughout Resident 8's entire admission with the provider, "there was a lot of concerns about meeting [his/her] basic needs." Case Manager EE also stated, "It was so disappointing that they [provider staff] weren't able to keep [him/her] clean and safe." Case Manager EE reported that Resident 8's MCO team had multiple meetings on site as well as a couple of visits where they observed staff's lack of follow through with Resident 8's cares. Case Manager EE reported that it was everyone's understanding from the start that staff would conduct Resident 8's nails cares and shaving because s/he required assistance with these from the start of his/her admission, but concerns were raised on multiple occasions of these not being done. Case Manager EE reported that s/he "definitely" had concerns that staff were not toileting Resident 8 every 2 hours or assisting him/her with incontinence cares as they should have been. Case Manager EE reported that when concerns were discussed during in-person meetings staff would report they would follow up on the concerns. Case Manager EE reported specifically that Former Administrator A had reported awareness that staff were not following through on Resident 8's care needs and were not following care plans. Case Manager EE reported that despite care concerns being raised about the lack of Resident 8's cares, the actual follow up and resolution to the issues did not seem to occur and the issues persisted throughout Resident 8's admission. Case Manager EE confirmed that staff were supposed to use a fall mat for Resident 8 at night throughout his/her admission, but staff follow through with actually using it "waxed and waned." Case Manager EE reported that Former	{N 425}		

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{N 425}	Continued From page 145 Administrator A and House Manager B were the primary contacts who Resident 8's MCO team contacted about care concerns and that both were "very well aware" of Resident 8's care concerns that persisted throughout his/her admission. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws N0247 DHS 83.22(1)-(4) Task Specific Training N0362 DHS 83.33(1)(d) Grievance Procedure: Written Summary N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	{N 425}		
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 observation, interview, and record review, the provider did not provide supervision appropriate to Resident 10's needs.	N 426		

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Resident 10 was admitted to the facility on 03/01/2024 and immediately began attempting to the leave the facility, as observed by caregivers and documented within Resident 10's record. Despite Resident 10's observed and documented attempts to the leave the facility, Resident 10 left the building without supervision on at least 2 separate occasions on 03/19/2024 and 04/08/2024. On 04/08/2024, Resident 10 was found in his/her wheelchair on the side of the road near local railroad tracks at approximately 7:00 A.M. by Caregiver Q traveling in his/her vehicle to work. The night shift caregiver was not aware of Resident 10's absence from the facility before Resident 10 was returned by Caregiver Q.

The findings include:

On 08/01/2024, the department received allegations including supervision appropriate to resident needs.

On 08/29/2024 at 7:25 A.M., Surveyor observed the distance from the facility with his/her vehicle, through the parking lot, and down the hill traveling east on Burke Road to the area between the railroad tracks crossing Burke Road and a stop sign at the base of the hill measured approximately 0.4 miles. Surveyor observed Burke Road contained a parallel, concrete sidewalk leading just a few feet passed a neighboring resident care apartment complex [RCAC] east of the facility. No sidewalk of any type on either side of Burke Road was observed to extend from near the neighboring RCAC's driveway entrance/exit to the base of the hill near the railroad tracks.

On 08/29/2024 at 12:15 P.M., House Manager B told Surveyor Resident 10 died at the facility on

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08/14/2024 and had been receiving hospice services. House Manager B provided Surveyor with Resident 10's individual service plan (ISP), not signed and not dated and Resident 10's caregiver observation notes. House Manager B told Surveyor Resident 10 started trying to leave the facility right away following Resident 10's admission to the facility. House Manager B said Resident 10 utilized a wheelchair for mobility and required assistance with transfers. House Manager B said Resident 10 would not always wait for caregivers to assist with transfers, but Resident 10 was only able to ambulate short distances on his/her own.
Resident 10 was admitted to the facility on 03/01/2024 with diagnoses including cognitive impairment, insomnia, agitation, and major depressive disorder. On 08/29/2024 at 3:41 P.M., House Manager B told Surveyor Resident 10's record was disassembled after Resident 10's death and s/he did not have access to Resident 10's signed ISPs at the facility. House Manager B told Surveyor s/he would forward Resident 10's signed ISPs from March 2024 through Resident 1's death in August 2024 to Surveyor on 08/30/2024. Surveyor did not receive any ISPs for Resident 10 from any staff member at the facility, including House Manager B.
Resident 10's ISP, not signed and not dated, included, "[Resident 10] has been identified as an elopement (leaving the facility without supervision) risk. To have proper precautions and redirection techniques in place to prevent elopement." Resident 10's ISP included, "[Resident 10] has been identified as a wandering risk, [Resident 10] has eloped 3 times, has been safely been [sic] returned to [the facility] without difficulty. To have proper redirection techniques in place to prevent wandering episodes. 15 minute checks. Staff/resident patterns of packing

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items is a sign of wanting to elope, staff can redirect with a game, maybe [s/he] is bored, needs something to help with in [sic] the building."
At 3:20 P.M., House Manager B told Surveyor Resident 10 had 2 elopements from the facility despite Resident 10's ISP identifying 3 elopements from the facility.
House Manager B provided Surveyor with copies of Resident 10's caregiver observation notes including the following documentation:
* 03/04/2024 note included, "[Resident 10] is so confused. [S/he] is looking for [his/her] [spouse] or [family member]. [Resident 10] try [sic] to leave. [Resident 10] goes to everybody's room to look for [his/her] loved ones. [Resident 10] pushing doors trying to scape [sic]. [Resident 10] sent outside to the back door. It was very hard to bring [Resident 10] back inside."
* 03/07/2024 note included, "[Resident 10] has been up all night asking for [his/her] [spouse] and [his/her] family. [Resident 10] kept banging on doors trying to find [his/her] way out of the building."
* 03/11/2024 note included, "[Resident 10] trying to escape sounding off alarms and opening every door."
* 03/19/2024 at 2:15 P.M. documentation by Former Administrator A included, "[Resident 10] eloped out of [facility]. [Resident 10] went out back door into fenced in area and proceeded to open the locked door in the fenced in area. [Resident 10] wheeled [self] all the way through the parking lot and down the sidewalk, parallel to the road, past the neighboring RCAC."
House Manager B provided Surveyor with a copy of Resident 10's "incident report" dated 03/19/2024 at 2:00 P.M. House Manager B told Surveyor s/he did not recall any details regarding the incident on 03/19/2024. This incident report included, "[Resident 10] went out back door and

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proceeded to get out of the gate in the fence. [Resident 10] continued to wheel [self] through the parking lot and down the street. Staff member found [Resident 10] and brought [him/her] back to the building. When asked where [Resident 10] was going, [s/he] replied, "I [Resident 10] was going home." The incident report included, "No" Resident 10's vital signs were not taken.
* 03/27/2024 note included, "[Resident 10] has been going in residents rooms waking residents up. [Resident 10] tried to escape. Staff tried to redirect [him/her] into the building. [Resident 10] stood up and hit staff in the face. [S/he] then began to trip over [his/her] wheelchair and fell."

On 08/29/2024 at 2:30 P.M., Surveyor conducted an interview with Caregiver Q. Caregiver Q, House Manager B, and Surveyor reviewed Resident 10's caregiver observation notes and incident report, as provided by House Manager B, as follows:
* 04/08/2024 note documented by Caregiver Q included, "Staff was driving to work when noticing [Resident 10] wheeling down the road. Staff pulled over, called supervisor and brought [Resident 10] back to the building."
House Manager B provided Surveyor with a copy of Resident 10's "incident report" dated 04/08/2024 at 10:00 A.M. The incident report included, "Staff was driving to work and noticed [Resident 10] wheeling down the road. Staff pulled over, called supervisor, then helped [Resident 10] get back to the [facility]."
Caregiver Q told Surveyor this incident on 04/08/2024 occurred at approximately 7:00 A.M., not 10:00 A.M. as documented within the incident report of the same date. Caregiver Q told Surveyor s/he was traveling west on Burke Road toward the facility on his/her way to work on the

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morning of 04/08/2024, at approximately 7:00 A.M., and saw Resident 10 sitting in his/her wheelchair when s/he approached the railroad tracks after stopping at the stop sign. Caregiver Q said Resident 10 was sitting on the same side of the road s/he was traveling (the north side of the road). Caregiver Q told Surveyor s/he did not recall what Resident 10 was wearing when s/he found him/her that morning, but s/he did not have any injuries. Caregiver Q said s/he assisted Resident 10 into his/her car and brought him/her back to the facility. Caregiver Q said the night shift caregiver remained in the facility when s/he brought Resident 10 back and that caregiver did not know Resident 10 had left the facility or was gone from the facility. Caregiver Q said s/he was not sure if the facility's front exit's alarm was functioning at the time, but s/he believed Resident 10 left through the back patio exit, went through the back gate before traveling through the parking lot and down Burke Road to the railroad tracks. Caregiver Q told Surveyor the railroad tracks remained active, but s/he did not see a train on the tracks on the morning of 04/08/2024 when s/he found Resident 10. Surveyor reviewed the weather history for 04/08/2024 at approximately 7:00 A.M. The temperature documented on 04/08/2024 at 7:00 A.M. was "44" degrees Fahrenheit. (Source: http://w.underground.com. Retrieval date - 08/29/2024.)

On 08/29/2024, House Manager B provided Surveyor with copies of Resident 10's caregiver observation notes including the following documentation:
* 04/30/2024 note included, "Wander guard came today and is all set up. [Resident 10] is still on 15 min [minute] checks and observation on night behaviors." House Manager B told Surveyor the

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N 426	Continued From page 151 wander guard system was only set up on the back exits leading to the patio because those exits were not alarmed. House Manager B told Surveyor the wander guard system was only used with Resident 10. On 08/29/2024 at 12:15 P.M., House Manager B told Surveyor s/he did know how Resident 10 was able to leave the building on 04/08/2024 before being found by the railroad tracks. House Manager B said s/he did not recall any incidents of Resident 10 leaving the facility without supervision after the incident on 04/08/2024. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws	N 426		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall	N 431		

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report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the provider did not ensure adequate health monitoring was provided to meet the needs of Resident 2 or Resident 9.

Resident 2 had a continuous glucose monitor [CGM] inserted, as prescribed, for the caregivers to utilize to monitor Resident 2's blood glucose twice daily, as prescribed. Resident 2's CGM was not maintained by facility and had expired resulting in an unnecessary need for finger sticks/pokes (process of poking Resident 2's skin with a lancet to draw blood before inserting in to a glucometer to achieve a blood glucose reading or level) by caregivers. On 08/29/2024, Caregiver O did not perform Resident 2's blood sugar, as prescribed.

Resident 9 was documented in his/her outside obtained hospice records as having left lower extremity cellulitis with varying signs of redness, swelling, tenderness, and an open blister from approximately 06/04/2024 up to 06/21/2024

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(approximately 2.5 weeks). The provider's staff were directed on 06/05/2024 to monitor Resident 9's foot. There was no evidence of how the provider's staff were monitoring Resident 9's lower extremity throughout this time other than to note that s/he had a "wound" on his/her "left leg" on 06/15/2024.

This requirement is being cited for the second time. See Statement of Deficiency (SOD) 54DT11, issued 03/24/2023.

The findings include:

On 07/22/2024 and 08/01/2024, the department received allegations including adequate health monitoring was not provided to meet the needs of residents.

Example 1: Resident 2's blood glucose monitoring

On 08/29/2024 at 8:20 A.M., Caregiver O told Surveyor s/he took Resident 2 his/her breakfast to eat in Resident 2's room, as requested by Resident 2.

On 08/29/2024 at approximately 8:32 A.M., Surveyor observed Resident 2 seated at the edge of his/her bed eating cereal and milk from a bowl with 1 piece of toast. Resident 2 said s/he was almost finished eating all of the cereal s/he had been served. Resident 2 told Surveyor s/he was not offered a piece of fruit, including a banana, with breakfast that morning.

On 08/29/2024 at 08:53 A.M., Caregiver O told Surveyor s/he was not sure if any residents have insulin ordered and stated, "I [Caregiver O] have to look." Caregiver O told Surveyor no insulin had

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been administered to any of the residents this morning.

On 08/29/2024 at 9:46 A.M., Surveyor observed Caregiver O prepare to administer Resident 2's oral, tablet medications and injectable insulin [diabetic medication] greater one hour after Resident 2 completed breakfast. Caregiver O dispensed Resident 2's oral medications into a small medication cup, including a metformin (a diabetic medication) 1000 mg tablet. Caregiver O locked the medication cart and shut the medication room door with the medication cup of Resident 2's oral medications in his/her hand. Surveyor asked if s/he had dispensed all of Resident 2's medications to be administered this morning, as prescribed. Caregiver O responded to Surveyor, "Yes." Surveyor asked if Resident 2 had blood glucose checks and/or insulin ordered to be administered in the morning. Caregiver O responded to Surveyor by opening the medication door, opening the medication cart, and removing a pen-syringe of humalog. Surveyor observed Caregiver O did not remove a glucometer, a device to check Resident 2's blood glucose, from the medication cart. Caregiver O entered Resident 2's room and administered Resident 2's oral medications, as dispensed. Surveyor observed Caregiver O dial 6 units of humalog insulin pen without first priming the syringe. Caregiver O appeared to administer the insulin to Resident 2's abdomen. Caregiver O said, "I [Caregiver O] am not sure if the insulin went in." Caregiver O wiped the injection site with a tissue. Resident 2 said s/he didn't really feel it, except his/her skin felt wet. Surveyor observed Caregiver O did not check Resident 2's blood glucose level. Caregiver O left Resident 2's room, returned to the medication cart, and documented administration of Resident 2's

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medications at 9:54 A.M.

On 08/29/2024 at 10:06 A.M., Surveyor conducted an interview with Resident 2. Resident 2 told Surveyor s/he did not have his/her blood glucose checked this morning. Resident 2 said his/her blood glucose was supposed to be monitored before s/he eats breakfast in the morning. Resident 2 told Surveyor the caregivers often ignore him/her when s/he asks them to administer insulin, as prescribed, before s/he is served and eats a meal. Resident 2 said the caregivers control administration of all of his/her medications. Resident 2 told Surveyor s/he was concerned about his/her blood sugar getting higher if it was not monitored consistently and insulin not administered, as prescribed.

On 08/29/2024 at 10:19 A.M., Surveyor observed Caregiver O sitting in a chair located near the back patio door and looking down at a phone. Surveyor asked Caregiver O about Resident 2's blood glucose monitoring. Caregiver O told Surveyor Resident 2's blood glucose was to be checked on an "as needed" basis, not scheduled, and that was why s/he did not check his/her blood glucose this morning.

On 08/29/2024, Surveyor reviewed Resident 2's August 2024 MAR including practitioner's orders, as provided by House Manager B. Resident 2's practitioner's orders, as received, included the following directions for Resident 2's humalog insulin dose "inject 6 units subcutaneously [beneath the skin] three times a day before meals. Blood sugar twice daily at 8 A.M. and 5 P.M."

On 08/29/2024 at approximately 11:59 A.M., another Surveyor observed Caregiver O begin

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serving lunch plates to residents seated in the dining room. Resident 2 was then observed eating lunch. At approximately 12:09 P.M., Surveyor observed Caregiver O serve a second helping of lunch to Resident 2. After this, Surveyor briefly interviewed Caregiver O. Caregiver O reported s/he was going to pass the noon medications but was not sure where the other staff member who was supposed to be working was to assist.

On 08/29/2024 at approximately 12:16 P.M., another Surveyor observed Caregiver O begin the noon medication pass. At approximately 12:25 P.M., Surveyor observed Caregiver O at the medication cart. On the laptop screen on top of the cart, Surveyor observed an order displayed for Resident 2's insulin, which indicated that 6 units of insulin were to be administered before meals. Caregiver O confirmed s/he had yet to administer Resident 2's insulin. Surveyor observed that Resident 2 was already finished with lunch and absent from the dining area. Caregiver O was observed inspecting a lancet, which s/he reported was not sure worked. Caregiver O referred to the lancet as Resident 2's "insulin needle," reported that Resident 2 did not have "insulin needles," and stated, "They never have them." Caregiver O reported s/he was not sure if the "insulin needle" worked. Caregiver O spent a couple more minutes looking in the cart and inspecting the lancet. Caregiver O and Surveyor then walked to Resident 2's room and observed him/her sitting on his/her bed watching television. Caregiver O then spent approximately 5 minutes inspecting the lancet again. Caregiver O attempted to poke Resident 2's finger with the lancet, but it did not draw blood. Caregiver O then stated, "I don't understand this stuff. It doesn't work," and left the room. Upon returning to the

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medication cart, Caregiver O stated that s/he "will have to figure this out." Caregiver O returned the lancet to the medication cart and documented on the laptop that Resident 2 refused his/her lunchtime insulin due to not having insulin needles in the cart. Caregiver O then closed up the medication cart and reported that s/he was done with the lunchtime medication pass. Surveyor observed that Resident 2 did not get his/her blood sugar tested or scheduled insulin administered.

On 08/29/2024 Surveyor reviewed Resident 2's August 2024 MAR, as provided by House Manager B. Resident 2's August MAR included the following documentation by Caregiver O at 12:29 P.M., "Humalog...(as prescribed) no pass reason: Refused. No insulin needles in med [medication] cart. Blood sugar tools are not working."
Surveyor reviewed Resident 2's practitioner's orders, as provided by House Manager B, including an order dated 05/20/2024, "Freesty [FreeStyle] Libr [Libre] 2 Senor [Sensor] Kit (a continuous glucose monitor [CGM] inserted under the skin)...subcutaneous" and "[replace] every 14 days."

On 08/29/2024 at 12:24 P.M., Surveyor conducted an interview with House Manager B regarding Resident 2. House Manager B told Surveyor Resident 2 was an accurate historian. House Manager B told Surveyor Resident 2 was admitted to the facility from his/her own home because Resident 2 was not taking his/her medications correctly on his/her own. House Manager B said Resident 2 has diagnoses including diabetes and required daily insulin injections. House Manager B told Surveyor Resident 2's blood glucose monitoring was not

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ordered "as needed" but rather to be checked before Resident 2 was administered insulin and before Resident 2 was served a meal. House Manager B told Surveyor Resident 2 should be administered all medications as prescribed by his/her practitioner.

On 08/29/2024 at approximately 12:40 P.M., Surveyor interviewed Resident 2. Resident 2 reported that staff were "supposed to" test his/her blood sugar before his/her meals but they typically tested it after s/he already ate. Resident 2 reported s/he had an arm sensor that could be used with a meter to read his/her blood sugar but that staff typically waited until the sensor died before reordering, which meant that staff would have to prick his/her finger in the meantime. Resident 2 reported that half of the time staff could not get the lancet to work and s/he thought some staff did no.t know how to use it. Resident 2 reported that his/her fingers became sore with repeated finger pricks and that is why s/he preferred for staff to monitor his/her blood sugar through his/her arm sensor. Resident 2 reported that it had been approximately 2-3 weeks since s/he last had an a working arm sensor. While interviewing Resident 2, Surveyor did not observe an arm sensor on either of Resident 2's upper arms, where s/he had indicated his/her previous sensor(s) as being placed.

On 08/29/2024, Surveyor reviewed Resident 2's individual service plan [ISP] and Resident 2's caregiver observation notes between 08/01/2024 and 08/29/2024, as provided by House Manager B. House Manager B told Surveyor s/he was unable to locate a signed, dated ISP for Resident 2. Resident 2's unsigned and undated ISP did not address Resident 2's use of a CGM, blood glucose monitoring system or how the facility

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planned on managing this system to ensure Resident 2's sensor was replaced upon expiration and functioning. Resident 2's caregiver observation notes did not include any documentation related to the management of, use of, or replacement of Resident 2's CGM.

On 08/29/2024 at 1:28 P.M., Surveyor conducted an interview with House Manager B. House Manager B told Surveyor Resident 2's blood glucose arm sensor, a CGM, expired approximately one week ago, "at least." House Manager B told Surveyor s/he believed Facility Nurse N had ordered a new CGM for Resident 2. House Manager B told Surveyor Resident 2 could have glucose monitoring performed by "finger pokes" in the meantime, but Resident 2 prefers to have his/her prescribed sensor used. House Manager B told Surveyor the caregivers passing medications are to check 5 days before Resident 2's CGM expires and call the pharmacy to request replacement of Resident 2's CGM. House Manager B told Surveyor s/he had not been informed by any caregiver of Resident 2's CGM running low, when it was about to expire, or that they were not able to use Resident 2's CGM.

Example 2: Resident 9

At approximately 1:30 p.m., Surveyor interviewed Social Worker JJ, from Resident 9's hospice team. Throughout the interview, Resident 9 was not observed to participate, even when introduced to Surveyor, and was observed to sit in his/her recliner with his/her eyes closed. Social Worker JJ reported Resident 9 required staff assistance for all cares.

On 08/29/2024, Surveyor reviewed Resident 9's record. Resident 9 was admitted to the provider

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on 03/26/2020 with diagnoses including mild cognitive impairment. Resident 9 was documented as having an activated power of attorney (POA) for healthcare and receiving hospice services. Surveyor reviewed Resident 9's observation notes from 05/01/2024 - 08/29/2024 and observed an entry dated 06/15/2024 at 6:30 a.m. which documented, "[S/HE] HAS A WOUND ON [HIS/HER] LEFT LEG." No other information about this wound was documented throughout the observation notes.

On 09/03/2024, at approximately 12:32 p.m., Surveyor e-mailed Administrator M and House Manager B requesting "any additional incident reports or notes in [Resident 9]'s record regarding [his/her] ...or leg wound from 06/15/2024" due by the end of the day.

On 09/04/2024, Surveyor reviewed the records e-mailed back by House Manager B. The following was observed:

- Hospice communication note dated 06/05/2024 from a hospice certified nursing assistant (CNA) to the facility staff, which documented, "Monitor foot, eating very little."

- Hospice communication note dated 06/11/2024 from a hospice CNA to the facility staff, which documented, "Please leave socks off!"

- Hospice communication note dated 06/13/2024 from a hospice registered nurse (RN) to the facility staff, which documented, "[Resident 9]'s Leg [sic] is looking a bit better but due to the swelling [s/he] should not have socks on until the infection clears - I put a note saying such just above [his/her] bed. Please call with any concerns or changes. Thanks!"

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N 431	Continued From page 161 - Hospice communication note dated 06/14/2024 from a hospice CNA to the facility staff, which documented, " ...foot looking better." Surveyor noted that the above 4 hospice communication notes, which identified a concern with his/her lower extremity, ranged from 06/05/2024 - 06/14/2024, compared to the observation note entry (above) from 06/15/2024. Surveyor noted that there was no evidence of how staff were monitoring Resident 9's foot, as first directed by his/her hospice agency on 06/05/2024. Surveyor reviewed Resident 9's individual service plan (ISP), dated the day of the on-site survey (08/29/2024) which did not identify any health monitoring information or specific lower extremity-related concerns. On 09/13/2024, at approximately 12:23 p.m., Surveyor interviewed Director of Clinical Services GG from Resident 9's hospice agency about Resident 9's lower extremity. Director of Clinical Services GG reported that on 06/04/2024, a nurse case manager had visited Resident 9 and first observed that his/her left lower extremity had edema and that the skin of his/her calf had been mottled, discolored, painful, and warm to touch. The visiting nurse case manager noticed that Resident 9 had been wearing a sock that had put excessive pressure on Resident 9's leg. The visiting nurse case manager consulted with the hospice medical provider who then ordered antibiotics to treat what was presumed to be an infection of Resident 9's lower extremity. Director of Clinical Services GG reported that another nurse, who visited Resident 9 on 06/10/2024 noted that the antibiotics had no positive effect on	N 431		

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his/her leg infection, with his/her left lower extremity below the knee to his/her toes appearing discolored, edematous, red around his/her ankle, and having an open blister on his/her left lateral ankle. Director of Clinical Services GG reported that the nurse noted s/he spoke with Former Facility Licensed Practical Nurse (LPN) S about Resident 9's leg and left a communication note about the concern. Director of Clinical Services GG reported that on 06/13/2024 visiting nurses had noticed decreased lower extremity swelling, and on 06/18/2024 continued improvement, although Resident 9's lateral ankle still had an area of skin that was healing. Director of Clinical Services GG reported that the visiting nurse on 06/18/2024 had also noted that s/he had spoken with facility staff about Resident 9's leg. Director of Clinical Services GG reported that on 06/21/2024, Resident 9's lower extremity concerns seemed to have resolved.

On 09/19/2024, Surveyor reviewed Resident 9's hospice records, obtained directly from his/her hospice agency, which documented the following:

1. RN visit note dated 06/10/2024, under the "Infection Assessment" heading:
- Onset Date: 6/4/2024
- Signs and Symptoms: Redness, swelling, tenderness, other: "from the knee to toes the skin is colored tan/yellow with red mottling and very red patch around the lateral ankle"
- Location/Site(s): Other: "small suspected entry point at lateral ankle"
- Treatment: Antibiotics: Yes
- Under the "Narrative Notes" heading: "[Resident 9] has been taking [antibiotics] for 5 days with no positive effect in the leg infection. [His/her] [left] lower leg from just below the knee to the toes is

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edematous, discolored with tan/yellow tint, has red areas around ankle and especially red around lateral ankle. There is an open blister on [his/her] left lateral ankle which is the suspected entry point based on earlier assessment. After discussion with [Resident 9]'s POA and [medical provider], Bactrim was added in hopes of overcoming the cellulitis infection in [his/her] lower right [sic] leg. Facility nurse [Former Facility LPN S] was updated in person, communication note was left in [hospice agency] book, ..."

2. RN visit note dated 06/13/2024, under the "Infection Assessment" heading:
- "more swelling, redness, and a blister over this site"
- Under the "Narrative Notes" heading: "The swelling on [Resident 9] is [sic] lower left leg has decreased a bit, down to plus two / plus three from knees to toes. [Resident 9] reported no pain yet on palpation of [his/her] lower leg . [sic] [S/he] grimaced. Writer confirmed with facility staff that [Resident 9] should not be wearing socks until [his/her] infection clears due to the constriction around [his/her] ankle and writer placed sign above [Resident 9]'s bed same. Facility staff ...updated in person, and communication note left in office."

3. Chaplain visit note dated 06/17/2024: " ...this writer noticed a disparity in the coloration of [Resident 9]'s feet. This writer offered an update to the [RN case manager] regarding this, who will see [Resident 9] tomorrow."

4. RN visit note dated 06/18/2024: "[Resident 9]'s [left] lower leg infection is improving ...The lateral ankle still has a healing area of bright red skin with some impaired skin over the surface, presumably the entry point for the infection.

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N 431	Continued From page 164 Facility staff ...were updated in person, communication note left in office ..." 5. RN visit note dated 06/21/2024: "[Resident 9] permitted writer to assess [his/her] lower left leg which was recovering from a cellulitis infection. [S/he] had no more swelling in the leg, reported no pain with movement or palpation, and had lessened redness around the ankles. The skin from [his/her] claves to [his/her] toes is dry and peeling ...Communication note was left in office ..." Upon comparing Resident 9's outside hospice agency records with his/her observation notes and records provided by House Manager B, there was no evidence that the changes being tracked from Resident 9's left lower extremity cellulitis (first noted by hospice on 06/04/2024 and continuing until 06/21/2024) were being monitored by provider staff. Summary: The provider did not ensure adequate health monitoring was provided to meet the needs of Resident 2 or Resident 9. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medications	N 431		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or	N 432		

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N 432	Continued From page 165 arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure that the CBRF provided medication administration appropriate to Resident 12's, Resident 11's, and Resident 9's needs. Caregiver O dispensed and handed a prescribed, controlled substance medication to Resident 12 in a medication cup during the morning medication pass and dispensed and handed medications to Resident 12 and Resident 11, individually, in medication cups during the lunch time medication pass without witnessing whether the medications were taken by each resident. Resident 12's lunch time medication pass included a prescribed narcotic medication. Caregiver O did not conduct any sort of follow up to see whether the prescribed medications dispensed during the medication passes were taken by each resident. On 08/28/2024, Resident 9 was documented as being at end of life by his/her hospice nurse. Because of this, scheduled morphine every 4 hours was initiated on 08/28/2024. Later on 08/28/2024, the frequency of his/her morphine administration was directed to staff to be changed to every 8 hours. Despite this, there was no evidence to suggest what morphine orders were being followed by staff on 08/29/2024 or that staff attempted to troubleshoot the changing	N 432		

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prescription instructions. As of the afternoon on 08/29/2024, there was no evidence that Resident 9 received any morphine yet that day, and the last administered dose was on 08/28/2024 at 7:35 p.m. (indicating that neither order was being followed). During the lunchtime medication pass on 08/29/2024, Surveyor observed that Caregiver O was not able to reconcile the differences between Resident 9's as needed (PRN) morphine and his/her scheduled morphine. Caregiver O documented that Resident 9 "refused" his/her scheduled morning and lunchtime morphine despite not having attempted to administer it. Though Caregiver O correctly identified that the only morphine s/he observed on hand in the medication cart, Resident 9's PRN morphine supply, was not the same supply as Resident 9's scheduled morphine, Caregiver O did not follow up with any other staff, including House Manager B, who was onsite throughout the day, to reconcile the discrepancy.

The findings include:

Example 1: Witnessing Resident 12's and Resident 11's medication ingestion

According to the guidebook developed by the University of Wisconsin - Green Bay for its trainers' medication administration courses, approved by the Department, CBRF staff who administer medications are directed to, "Observe the resident to ensure that the medication was ingested if taken orally," (Source: University of Wisconsin - Green Bay, Medication Administration Training Participant Guide, March 2020).

On 08/29/2024, Surveyors conducted a complaint investigation into concerns that staff

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administering medications were not watching the ingestion of medications to ensure residents had actually taken the medications that were administered.

On 08/29/2024, at approximately 9:34 A.M., Surveyor observed Caregiver O dispense Resident 12's prescribed methylphenidate (a controlled substance: a stimulant medication often prescribed for attention-deficit hyperactivity disorder, ADHD) 20 mg (milligram) tablet in to a medication cup from a unit dose packaging card located within a locked compartment within the facility's medication cart. Surveyor observed Resident 12's electronic medication administration record [MAR] included the following practitioner's order, "Methylphenidate 20 mg...take 1 tablet by mouth three times a day." Surveyor observed Caregiver O walk to Resident 12's room, knock on Resident 12's closed door, and state, "I [Caregiver O] have your [Resident 12's] 10:00 A.M. pill." Surveyor observed Resident 12 open his/her room door approximately 3 inches and Caregiver O handed Resident 12 the medication cup containing the methylphendate tablet through the opening. Resident 12 took the medication cup and closed the door. Caregiver O did not observe Resident 12 ingest the methylphendate dose and walked back to the medication room. Surveyor asked Caregiver O why s/he did not watch Resident 12 ingest the methylphenidate tablet. Caregiver O responded, "[Resident 12] loves [his/her] pills and [caregivers] do not have to watch [Resident 12] take them." Caregiver O documented administration of Resident 12 s' methylphendate dose within Resident 12's electronic MAR at "9:35 A.M."

On 08/29/2024, at approximately 12:16 P.M.,

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another Surveyor observed Caregiver O conduct lunchtime medication administration. The medication cart was located in a medication room, positioned such that Caregiver O would specifically have to lean out the doorway, past where Surveyor stood, to view the dining area. Caregiver O dispensed tablets into a medication cup, handed the cup to Resident 12, who was seated at a dining table, then immediately walked back to the cart to prepare the next resident's medications. Surveyor did not observe Caregiver O observe whether Resident 12 took the medications from the cup handed to him/her. From then until approximately 12:30 p.m., Surveyor observed Caregiver O conduct the entire lunchtime medication pass. At approximately 12:30 p.m., Caregiver O locked up the cart and told Surveyor s/he was done with the lunchtime medication pass. Surveyor observed the dining area and observed that Resident 12 was no longer present and the tables were cleared. Surveyor did not observe Caregiver O follow up with Resident 12 to ensure the medications s/he handed to Resident 12 were ingested by Resident 12. Surveyor reviewed Resident 12's August 2024 MAR, including Caregiver O's documentation of Resident 12's prescribed oxycodone [narcotic pain medication] 5 mg dose administered to Resident 12 at 12:16 P.M.

On 08/29/2024 at approximately 12:38 P.M., Surveyor conducted an interview with House Manager B regarding Resident 12's medications and administration of medications. House Manager B told Surveyor caregivers were responsible for administering Resident 12's medications, including methylphenidate and oxycodone. House Manager B said the caregivers needed to observe Resident 12 take

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his/her medications because Resident 12 can not be trusted to ingest them when not observed directly. House Manager B told Surveyor Resident 12 was manipulative with medications and would attempt to manipulate caregivers by repeatedly requesting administration of medications outside the times they were prescribed. House Manager B said s/he would be concerned Resident 12 would pocket medication, or not ingest when given, especially methylphenidate and/or oxycodone, and "stock pile" medications if not directly observed by caregivers to ensure s/he ingested the medication. House Manager B said s/he was also concerned because Resident 12 was currently drinking alcohol again. House Manager B told Surveyor Resident 12 had a significant history of manipulation surrounding medication administration and "stock piling" medications.

On 08/29/2024 at 4:02 P.M., Surveyor conducted an interview with Administrator M, including a discussion about Resident 12's medication administration. Administrator M told Surveyor Resident 12 was known to manipulate caregivers with intimidation regarding administration of his/her medications. Administrator M told Surveyor Resident 12 could be "stock piling" medications if the caregivers were not observing Resident 12 ingest the dispensed medications.

On 08/29/2024 at 6:37 P.M., Surveyor received an email from House Manager B, including Resident 12's individual service plan [ISP] dated 08/23/2024. Resident 12's ISP included Resident 12's diagnoses including "ADHD." Resident 12's ISP included, "[Resident 12] displays destructive behaviors. [Resident 12] has thrown things before when upset or when [s/he] does not get [his/her] medications when [s/he] wants them."

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Resident 12's ISP included, "[Resident 12] needs bags checked for alcohol when [Resident 12] comes back from an outing. [Resident 12] has been sneaking it in." Resident 12's ISP included, "Monitor for the following: Can get mad and yell at staff about [his/her] medications if [s/he] doesn't [sic] get them when [s/he] wants them...to keep [Resident 12]/peers in safe environment." Resident 12's ISP included, "Staff controls medication administration due to dementia diagnosis" and "to maintain proper medication regime."

Example 1 continued: Witnessing Resident 11's medication ingestion

On 08/29/2024, at approximately 12:16 p.m., Surveyor observed Caregiver O conduct lunchtime medication administration. The medication cart was located in a medication room, positioned such that Caregiver O would specifically have to lean out the doorway, past where Surveyor stood, to view the dining area. Surveyor then observed Caregiver O dispense 1 tablet of Resident 11's levodopa (a medication used to manage motor symptoms of Parkinson's disease) into a medication cup. Caregiver O walked back out to the dining area, where Resident 11 was seated at a table, and handed the cup to him/her. Caregiver O then immediately walked back to the cart to prepare the next resident's medications. Surveyor did not observe Caregiver O observe whether Resident 11 took the medications from the cup handed to him/her. Surveyor stood in the hallway in view of the dining area, including Resident 11's table. Surveyor observed Resident 11, who was eating lunch when handed the medication cup by Caregiver O, place the medication cup with the tablet onto the table next to his/her plate. Six other residents,

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N 432	Continued From page 171 including Resident 2, Resident 4, Resident 5, Resident 12, Resident 7, and Resident 13) were also in the dining area at this time eating lunch. From then until approximately 12:30 p.m., Surveyor observed Caregiver O conduct the entire lunchtime medication pass. At approximately 12:30 p.m., Caregiver O locked up the cart and told Surveyor s/he was done with the lunchtime medication pass. Surveyor observed the dining area and observed that Resident 11 was no longer present and the table was cleared. Surveyor did not observe Caregiver O follow up with Resident 11 to ensure that s/he ingested the medication s/he handed Resident 11. Example 2 - Resident 9's scheduled morphine On 08/29/2024, at approximately 12:16 p.m., Surveyor observed Caregiver O conduct lunchtime medication administration. Surveyor observed Caregiver O pull out a bag of morphine syringes, prescribed to Resident 9. Caregiver O looked several times between the pharmacy label on the bag and the order on the screen of the laptop, which was located on the medication cart. Afterwards, Caregiver O put the bag back in the cart. At approximately 12:30 p.m., Caregiver O locked up the cart and told Surveyor s/he was done with the lunchtime medication pass. Surveyor requested Caregiver O to review Resident 9's morphine. Caregiver O pulled up Resident 9's morphine order on the laptop and showed Surveyor the morphine bag that s/he was inspecting earlier from the medication cart. The pharmacy label on the bag documented that the bag contained "Morphine 100 mg/5 mL solution", dispensed on 08/28/2024, with instructions to,	N 432		

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"Take 0.5 mL (10 mg) by mouth every hour as needed for severe pain / shortness of breath ...*prefilled syringes*" A handwritten date of "08/28/2024" was on the sticker indicating the date it was opened. A handwritten note in marker on the bag documented: "(#20 [pre-filled syringes] = 10 mL."

The order on the laptop showed "Morphine sulf[ate] 20 mg/mL sol" with instructions to, "Take 0.5 mL by mouth every 4 hours for pain or shortness of breath." The time for the administration that was supposed to have just recently occurred was 12:00 p.m. Surveyor observed that these directions seemed to reflect a scheduled dose of morphine, as opposed to the PRN morphine observed in the cart.

While reviewing the bag and order, Caregiver O reported that s/he didn't think the order on the laptop screen matched the label on the bag, and so s/he did not administer the morphine either earlier that day or during lunchtime. Caregiver O reported that the morphine supply reflected in the computer order was missing.

Caregiver O was not observed to ask for guidance from anyone in order to clarify the administration of Resident 9's morphine either during the medication pass or after reviewing the morphine discrepancy with Surveyor. House Manager B was observed in the facility throughout the lunchtime medication pass as well as through the time Caregiver O was observed to leave the facility at the end of his/her shift at approximately 3:00 p.m.

At approximately 6:50 p.m., Surveyor observed the medication cart with Caregiver K and House Manager B. House Manager B denied that

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COTTAGES OF MADISON APPLEWOOD	5565 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 432	Continued From page 173 Caregiver O brought up any questions or concerns to him/her related to Resident 9's morphine administration that day. On top of the medication cart, Surveyor observed a piece of paper that appeared to be from a notepad. On the paper was a handwritten note: "Every 8 hours for morphine and lorazepam [as] need for pain. I give the lorazepam and the morphine together so [s/he] can be comfortable. Thank you." Surveyor did not observe any evidence as to who the note was documented by or which resident it referenced. Caregiver K reported s/he wasn't sure who wrote the note but that s/he thought it was either placed on the cart that day or the day before. Caregiver K reported s/he thought the note referenced Resident 9. On 08/29/2024, Surveyor reviewed Resident 9's August MAR. Surveyor observed 2 separate orders for morphine - 1 that was a scheduled dose and 1 that was a PRN dose. The concentration of both doses was the same. The scheduled dose instructions were to, "Take 0.5 mL by mouth every four hours for pain or shortness of breath," which corroborated with the scheduled 12:00 p.m. order that Surveyor observed earlier on the laptop with Caregiver O. The start date for the scheduled dose order was 08/28/2024 (the previous day). The times set on the MAR for the scheduled dose to be given was 12:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. The PRN dose instructions were to, "Take 0.5 mL (10 mg) by mouth every hour as needed for anxiety, agitation, restlessness," which corroborated with the pharmacy label on the PRN bag of morphine syringes that Surveyor observed earlier in the medication cart with Caregiver O. The PRN dose was active as of 06/01/2024. Surveyor observed that Caregiver O had documented that Resident 9 had refused 2	N 432		

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N 432	Continued From page 174	N 432		

doses of his/her scheduled morphine that day - at 8:00 a.m. and 12:00 p.m. Surveyor noted that this conflicted with the lunchtime medication pass observations as well as Caregiver O's earlier report that s/he held the morphine due to concern that the morphine orders didn't match. Resident 9's scheduled morphine dose was initialed off as administered on 08/28/2024 at 4:00 p.m. and 8:00 p.m. but was blank for 12:00 a.m. on 08/29/2024 (prior to the survey).

On 09/05/2024, at approximately 3:13 p.m., Surveyor interviewed Director of Clinical Services GG, from Resident 9's hospice agency. Director of Clinical Services GG confirmed that 100 mg/mL of morphine (from the label on Resident 9's PRN morphine bag) was the same dose concentration as the 20 mg/mL solution that was from Resident 9's scheduled morphine order, but the 2 supplies were maintained separately. Director of Clinical Services GG reported that s/he was reviewing the hospice notes for Resident 9, and that between 1:00 a.m. - 2:00 a.m. on 08/28/2024 a nurse had conducted a visit with Resident 9 due to staff reporting that s/he was crying and yelling out in pain. An order for scheduled morphine to be given every 4 hours was then initiated at 7:14 a.m. that morning because of this. Director of Clinical Services GG then reported that later in the afternoon on 08/28/2024, a nurse conducted a follow up visit with Resident 9 and noted that s/he appeared to be more comfortable. Because of this, the order with instructions for morphine administration every 4 hours was discontinued and a new order was placed for scheduled morphine to be administered every 8 hours starting at 4:52 p.m. Surveyor noted that this new order, for administration every 8 hours, seemed to correlate with the handwritten note that was observed on

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the medication cart on 08/29/2024 except that the handwritten note seemed to indicate PRN administration. Director of Clinical Services GG confirmed that the "every 8 hours" morphine was a scheduled, not PRN, prescription, and that there were no changes to Resident 9's standing PRN morphine order.

On 09/06/2024, Surveyor reviewed outside hospice records obtained for Resident 9 regarding his/her morphine and observed the following:

- Nurse note from visit dated 08/28/2024 between 2:00 p.m. - 3:00 p.m. documented that information was shared with Administrator M, House Manager B, and Caregiver F that Resident 9 was "most likely transitioning to end of life." The note also documented: "Medication updates shared and new orders placed for morphine administration to happen every 8 hours for pain treatment. Education given on using PRN morphine, especially premedication if transfers or extensive cares are needed and watching for non-verbal signs and symptoms of pain. Caregivers encouraged to call [hospice agency] with any concerns, questions, or change of status updates."

- Order for morphine 20 mg/mL oral concentrate with instructions to administer 0.5 mL orally every 4 hours for pain or shortness of breath - placed on 08/28/2024 at 2:30 a.m. and signed off on by Resident 9's hospice medical provider at 9:16 a.m. that morning.

- Discontinuation of the above scheduled morphine order and new order for morphine 20 mg/mL oral concentrate with instructions to administer 0.5 mL orally every 8 hours for pain or

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shortness of breath - placed on 08/28/2024 at 4:34 p.m. but not signed off on by Resident 9's hospice medical provider until 09/03/2024 at 6:41 a.m. (after Surveyor had been on site).

Based on the changing orders it was unclear whether staff were following the "every 4 hours" administration direction or the "every 8 hours" administration direction as of 08/29/2024 (when Surveyors were on site). While the hospice nurse's note from the afternoon of 08/28/2024 documented specifically that staff, including Administrator M and House Manager B, were given an update to administer Resident 9 scheduled morphine every 8 hours, the delayed signing of the order from Resident 9's medical provider as well as his/her MAR from 08/29/2024 indicated that staff were following the "every 4 hours" administration direction. There were no notes in Resident 9's record, including his/her observation notes, that documented which order staff were following or staff attempts to work through the changes in his/her morphine administration directions from hospice. In reviewing Resident 9's August MAR again, Surveyor observed that his/her last morphine dose was administered on 08/28/2024 at 7:35 p.m. Since Caregiver O had documented that Resident 9 "refused" his/her 08/29/2024 8:00 a.m. and 12:00 p.m. morphine doses Surveyor observed that regardless of what scheduled morphine order staff were following, Resident 9 had not been administered morphine on the morning of 08/29/2024 in accordance with either order.

Summary: The provider did not ensure that the CBRF provided medication administration appropriate to Resident 12's, Resident 11's, and Resident 9's needs.

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N 432	Continued From page 177 Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws N0409 DHS 83.37(1)(j) Proof-of-Use Record	N 432		
{N 452}	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that food was stored and served under sanitary conditions for the prevention of food borne illnesses. This requirement is being cited for the third time. See Statement of Deficiency (SOD) FT8K11, issued 03/17/2023, and SOD OCCY11, issued	{N 452}		

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{N 452}	Continued From page 178 06/17/2024. The findings include: Example 1 - Employee Hygiene According to the Food and Drug Administration (FDA) employees that handle food should wash their hands when they enter a food preparation area, before engaging in food preparation, after handling soiled dishes, and after eating and drinking. Bare hand use with ready-to-eat food is discouraged due to the potential for food contamination. Additionally, hair restraints should be worn (Source: U.S. Food and Drug Administration, Employee Health and Personal Hygiene Handbook, 2020, https://www.fda.gov/media/77065/download (retrieval date - September 3, 2024).). According to the Wisconsin Department of Agriculture, Trade and Consumer Protection (WI DATCP), food employees should wear hair restraints such as hair nets, hats, and beard nets that are effective in keeping hair under control (Source: WI DATCP, Wisconsin Food Code Fact Sheet: Employee Hygiene and Cleanliness, November 2020, https://datcp.wi.gov/Documents/EmployeeHygieneFactSheet.pdf (retrieval date - September 3, 2024).). On 08/29/2024, at approximately 8:05 a.m., Surveyor observed Caregiver O preparing breakfast for residents, which consisted of cereal, toast, and bananas. Caregiver O was observed to have braided hair pulled back into a ponytail at the base of his/her neck, with the remainder of his/her loose hair reaching his/her lower back area. Caregiver O was not observed to use a hair	{N 452}		

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{N 452}	Continued From page 179	{N 452}		

net while preparing breakfast.

At approximately 11:22 a.m., Surveyor observed Cook G preparing lunch at the provider's offsite kitchen, located in Cottages of Madison Oakwood - a community based residential facility (CBRF) next door. Cook G was observed preparing mashed potatoes and corn. Cook G was not observed wearing a hair net while preparing food.

At approximately 11:56 a.m., Surveyor observed Caregiver O preparing lunch plates for residents. Caregiver O was observed scooping out corn and mashed potatoes onto plates as well as placing slices of turkey with gravy on plates. Caregiver O's hair was still observed in a ponytail, with the remainder of his/her hair loose reaching his/her lower back area. Caregiver O was not observed to use a hair net while preparing lunch plates.

At approximately 12:01 p.m., Surveyor observed Caregiver O stop preparing and serving resident plates to assist Resident 9 to lunch. Caregiver O was observed leaving the kitchenette area and entering the hallway near Resident 9's room, where s/he then pushed Resident 9 in his/her manual wheelchair to the dining area. Caregiver O then physically assisted Resident 9 to a dining table from his/her wheelchair. Caregiver O then retrieved a plate from the kitchenette and served it to Resident 9. During the entire above interaction, Caregiver O was observed wearing the same pair of gloves with no hand hygiene conducted in between activities. Approximately 2 minutes later, Resident 9 was observed to get up and attempt to walk away from the table. Caregiver O placed hands on him/her to physically assist him/her back to the table. Caregiver O then went back to the kitchenette and prepared another lunch plate which s/he then

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{N 452}	Continued From page 180	{N 452}		

served to Resident 13. Between physically assisting Resident 9 and plating food for Resident 13, Caregiver O was observed wearing the same pair of gloves with no hand hygiene conducted in between activities.

At approximately 4:44 p.m., Surveyor observed Caregivers D and K plating dinner that they had reheated in the oven, which consisted of Texas toast and a chicken/pasta bake. Caregiver D's hair was observed pulled back in a short ponytail. Caregiver's K hair was also in a short ponytail, and s/he was wearing a knit-style cap on his/her head. Neither were wearing hair nets while preparing dinner.

Example 2 - Food Storing/Holding and Serving

According to the U.S. Department of Agriculture, hot food should be maintained at or above 140°F due to the risk of bacteria growth, which "grows most rapidly in the range of temperatures between 40°F and 140°F, doubling in as little as 20 minutes," (Source: U.S. Department of Agriculture, "Danger Zone" (40°F - 140°F), June 28, 2017, https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/danger-zone-40f-140f (retrieval date - September 3, 2024).).

On 08/29/2024, at approximately 12:40 p.m., Surveyor interviewed Resident 2. Resident 2 reported that a lot of the times hot foods were served cold.

At approximately 3:41 p.m., Surveyor observed Cook G drop off 2 containers of food in the provider's kitchenette that s/he prepared in the offsite kitchen in Cottages of Madison Oakwood.

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{N 452}	Continued From page 181 Cook G confirmed this was what was intended to be served for dinner. One container had bread, consistent in appearance to Texas toast, which was covered with plastic wrap, and the other container was covered with aluminum foil. Cook G placed both containers on the provider's kitchenette stovetop, which was not on, and left. At approximately 4:25 p.m. (approximately 44 minutes after the dinner food was dropped off), Surveyor observed Caregiver D begin to prepare the food from the containers for reheating, which included placing the pre-baked toast slices on a tray that was then placed in the oven, and placing the other container, which Caregiver D stated contained a chicken/pasta bake, into the oven. Caregiver D confirmed the food had been sitting on the stove for storing until s/he began preparing it. Caregiver D reported s/he would reheat the food in the oven for approximately 15 minutes prior to serving. At approximately 4:38 p.m., Surveyor observed Caregivers D and K plating dinner. Caregiver D served Surveyor a test plate of the chicken/pasta bake at the same time the first residents' plates were served at 4:44 p.m. Surveyor immediately took the chicken's temperature, which reached a maximum temperature of 118°F. Surveyor then interviewed Caregivers D and K, who both reported they were unaware of any food holding temperature regulations. Caregiver D reported that it was typical for Cook G to drop off dinner early due to his/her working hours, and s/he was the only staff who even reheated it prior to serving. Caregiver D reported s/he was concerned that other staff would typically just plate and serve dinner after the containers had been sitting out.	{N 452}		

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{N 452}	Continued From page 182 Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws	{N 452}		
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)	N 454		

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N 454	Continued From page 183 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, 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 that Resident 8's record was maintained to include the date, time, and circumstances of his/her death as well as the name of the person to whom his/her body was released. The findings include:	N 454		

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N 454	Continued From page 184 On 08/29/2024, Surveyor conducted a complaint investigation into concerns related to neglect of resident cares prior to death. On 08/29/2024, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider on 11/28/2023. Resident 8's face sheet documented that s/he was discharged on 07/17/2024. Resident 2's observation notes, reviewed from 05/01/2024 until 08/29/2024 (over 1 month after his/her discharge date), documented the following, from most to least recent: - Entry on 07/24/2024: Documented that Resident 8 was "discharged from the system" with the reason being "Deceased." - Entry on 07/21/2024 documented the same information as above. - Entry on 07/17/2024 (12:45 p.m.): "Resident ate lunch at table in a great mood sat out in dining area 30 minutes after eating. then [sic] went back to [his/her] room." - Entry on 07/16/2024 (6:00 p.m.): "slept all night." - Entry on 07/14/2024 (6:30 a.m.): "resident got up in the middle of the night wandering and turning [his/her] tv on max volume staff redirected [him/her] back to bed." - Entries on 07/05/2024, 07/07/2024, 07/08/2024, and 07/12/2024 each documented that Resident 8 either slept "all night" or "most of the night" without any other annotations in this timeframe. - Entry on 07/04/2024 (4:00 p.m.): "resident	N 454		

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keeps undressing [him/herself] instead of using call light to ask for help we change [him/her] every 2 hours but if [s/he] has an accident [s/he] will choose [his/her] independence and undress [him/herself]."

- Entries from 05/01/2024 through the morning of 07/04/2024 document short annotations about his/her sleeping/nighttime habits (e.g. "slept all night" or yelling at night), cares provided (e.g. being asked about toileting needs (1 entry), showering (1 entry), grooming (1 entry)), a podiatry visit (1 entry), and refusing cares (1 entry).

No entries, including in the above entries, documented any health concerns experienced by Resident 8 or any other information about his/her death (including the date it occurred.)

Surveyor reviewed all incident reports generated from Resident 8's admission until his/her discharge. The most recent incident report was dated 03/05/2024. No information was available in incident reports related to Resident 8's death.

Surveyor reviewed Resident 8's individual service plan (ISP), which documented that Resident 8 had "chronic illness(es) that require[d] proper treatment and management" but no other information regarding Resident 8 having health monitoring needs. Resident 8 was documented as being independent with eating as well as social/leisure activities. Resident 8 was documented as requiring "partial assistance from staff" for denture cleaning, dressing, and bathing. Resident 8 was documented as requiring "full assistance" for toileting. Resident 8 was documented as requiring the assistance of 1 for transfers and an unspecified level of "staff

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assistance" for ambulation but was noted to transfer him/herself due to forgetting to use his/her call light.

Resident 8 was not documented as receiving home health or hospice services at any point during his/her admission.

Surveyor reviewed Resident 8's task administration record (TAR), where staff initialed off on performing his/her cares. The TAR last contained entries on 07/17/2024 at 1:34 p.m. His/her evening care-related entries were all blank and the remainder of his/her entries after 07/17/2024 were grayed out.

Surveyor reviewed Resident 8's medication administration record (MAR), which showed that s/he received his/her morning medications. All entries for his/her 5:00 p.m. and 8:00 p.m. medications were blank. The remainder of his/her MAR entries after 07/17/2024 were grayed out.

Surveyor reviewed all available medical notes for Resident 8 throughout his/her admission. This included a provider note and after-visit summary - both of which were in relation to an emergency department admission Resident 8 had after s/he experienced a fall on the evening of 12/22/2023. Resident 8 was documented as being discharged in the early morning hours of 12/23/2023 (his/her entire admission having been approximately 7 months prior to his/her passing). Resident 8's diagnoses in his/her emergency department provider note included dementia, congestive heart failure, atrial fibrillation, hypertension, and coronary artery disease. His/her physical exam during that admission documented that s/he was "well-nourished", had full range of motion of all 4 limbs, was alert and following commands, and

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demonstrated "normal judgment."

There was no information regarding the circumstances of Resident 8's death or the name of the person to whom his/her body was released.

At approximately 5:37 p.m., Surveyor interviewed Caregiver D. Caregiver D reported that Resident 8 passed away on the evening of 07/17/2024. Caregiver D reported that Resident 8 was mostly independent with transfers and ambulation even up to the point of his/her passing. Caregiver D reported s/he was not working on 07/17/2024 but was called by another staff member at 6:47 p.m. to be informed that Resident 8 had passed away. Caregiver D reported s/he was surprised to hear that Resident 8 had passed away. Caregiver D reported s/he then went to the facility to pay his/her respects and say goodbye to Resident 8. Caregiver D reported that law enforcement and the coroner were on site when s/he got there shortly before 7:00 p.m. Caregiver D reported that paramedics who had been on site had already left. Caregiver D reported s/he often worked at the provider's facility and was unaware of any change in condition experienced by Resident 8 prior to his/her passing.

At approximately 8:18 p.m., Surveyor interviewed House Manager B. House Manager B reported s/he recalled Former Administrator A having e-mail correspondence with the coroner to get more information about Resident 8's death but that since Former Administrator A no longer worked with the provider s/he would have to work through human resources personnel to access the e-mails. House Manager B reported s/he believed there was a death investigation completed regarding Resident 8's passing but that it was in Administrator M's office, which was

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N 454	Continued From page 188 locked. Surveyor gave a deadline of 12:00 p.m. on 08/30/2024 to receive any additional information related to Resident 8's death. On 08/30/2024, Surveyor reviewed a document e-mailed by Administrator A, titled "[Resident 8] Statements." The document consisted of 7 pages with each page containing only several handwritten phrases or sentences. Pages 1-2, 4, and 5-7 documented staff statements related to dinner preparation and inconsistent statements of whether Resident 8 ate dinner that evening in the dining room or his/her room. Page 3 documented, "[Caregiver V] was in apple passing meds around 7:30 [s/he] went to pass [Resident 8] [his/her] meds + found [him/her] unresponsive on the ground." Nothing further was documented about what occurred after this. Between Resident 8's record, provided onsite, and the statements provided by Administrator M, was there no information about Resident 8's death, including the agencies that responded to Resident 8's initial unresponsiveness and subsequent death. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws	N 454		
{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.	{N 481}		

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This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure that the living environment was safe, clean, and homelike.

This requirement is being cited for the fourth time. See Statement of Deficiency (SOD) 54DT11, issued 03/24/2023, SOD FT8K12, issued 06/16/2023, and SOD OCCY11, issued 06/17/2024.

The findings include:

On 08/29/2024 at 11:10 A.M., Surveyor conducted an interview with Resident 2. Resident 2 told Surveyor s/he was supposed to be assisted by caregivers with shower and/or bathing. Resident 2 told Surveyor was not being consistently provided with assistance by caregivers with showers and/or bathing, so s/he began taking independent showers in the corner bathroom near his/her room on the opposite side of the hallway. Resident 2 and Surveyor entered the door leading in to the corner bathroom near Resident 2's room. Surveyor observed the door included a sign, "Restrooms." Surveyor observed the bathroom contained a sink, toilet, and a walk-in shower/tub. Resident 2 told Surveyor s/he "props" his/her wheeled walker against the inside of the door to the bathroom before locking the breaks to the wheeled walker because the door lock was "jammed" and did not lock. Resident 2 said s/he did this to to give him/her "a bit of fair warning if someone tried to come in to the bathroom when s/he was taking a shower. Resident 2 told Surveyor s/he sits down in the walk-in shower/tub and used the flexible, hand-held shower head to give himself/herself a

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shower. Surveyor observed the bathroom door's levered handle including a push-button lock within the handle. Surveyor observed the lock device was pushed in and could not be released by attempting to turn the handle or push the button. Surveyor shut the door from the outside and observed the door did not lock.
Resident 2 asked Surveyor to turn on the bathroom's ceiling exhaust fan with the switch located near the bathroom door. Surveyor did so and heard a very loud, grinding sound caused by the ceiling exhaust fan that echoed within the bathroom. Resident 2 said s/he did not turn the ceiling exhaust fan on when s/he showers in this bathroom because the sound was "too loud." Resident 2 told Surveyor the issues with the bathroom door lock and ceiling exhaust fan, as observed, had been on-going for "quite awhile." Resident 2 said s/he told several different caregivers about these issues, but felt the caregivers did not pay attention to what Resident 2 told them. Resident 2 said s/he did not know the names of the caregivers because none of them wear a name tag.

On 08/29/2024 at 12:24 P.M., Surveyor conducted an interview with House Manager B regarding Resident 2. House Manager B told Surveyor Resident 2 was an accurate historian. Surveyor shared the observations made by Resident 2 and Surveyor of the corner bathroom located near Resident 2's room, including the bathroom door lock being "jammed" and the loud ceiling exhaust fan. House Manager B told Surveyor s/he was not aware the door lock was not functioning and the ceiling exhaust fan was making a loud, grinding sound in the corner bathroom near Resident 2's room. House Manager B told Surveyor s/he would contact the facility's maintenance staff to fix the issues.

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{N 481}	Continued From page 191 Throughout the day on 08/29/2024, Surveyor toured the environment and observed the following: - At approximately 7:50 a.m., in bathroom "A", the toilet paper holder was empty. A roll of toilet paper was sitting on top of the toilet tank. At approximately 11:16 a.m., upon observing bathroom "A" again, the toilet paper holder continued to be empty and a roll of toilet paper was still sitting on top of the toilet tank. At approximately 4:04 p.m., Surveyor observed bathroom "A" again. The toilet paper holder continued to be empty and there was no longer a roll of toilet paper within reach of the toilet. - At approximately 7:52 a.m., the panel towards the bottom the gas fireplace located in the dining area was missing, exposing the lines and fireplace parts to the environment. The area under the fireplace contained small bits of debris. - At approximately 8:52 a.m., the back patio area was observed. Along the edge of the patio, two separate areas, approximately 3.5' x 2' and 2.5' x 2.5' appeared covered in cigarette butts. At approximately 2:51 p.m., Surveyor observed Resident 13 sitting in a chair on the back patio. At approximately 4:25 p.m., Surveyor interviewed Residents 7 and 12 about outdoor use. Both reported that Resident 13 liked to frequently hang out outside on the back patio. At this same time, Surveyor interviewed Caregivers D and K. Both reported that there were no residents who smoked cigarettes. Caregiver D reported that the last resident who was known to smoke had moved out approximately 2 months ago. - At approximately 11:07 a.m., the kitchenette	{N 481}		

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was observed. An approximate 1' x 1' area of tile was missing in front of the dishwasher. The overhead light covering contained debris and dead insects.

- At approximately 11:14 a.m., Surveyor toured the bathrooms and observed 1 lightbulb out in the fixture located above the sink for 3 of 3 resident bathrooms (bathroom "A", an unmarked bathroom, and bathroom "C"). At approximately 4:07 p.m., Surveyor observed the bathrooms again, which remained unchanged with 1 lightbulb out in each of the 3 bathroom fixtures.

- At approximately 12:49 p.m., Surveyor observed Resident 13's room. The wall outlet near his/her closet was observed without a cover plate.

On 10/02/2024, at approximately 2:49 p.m., Surveyor interviewed House Manager B and Administrator M regarding the above areas of concern. Administrator M reported that s/he had ordered commercial-style toilet paper holders that would be capable of holding multiple rolls for the bathrooms. Regarding the fireplace, Administrator M reported s/he had noticed the area prior to the survey and was working on a solution to cover it. Regarding the cigarette butts, Administrator M reported that at the time of the survey, Resident 12 was a smoker and sometimes smoked on the back patio. Administrator M reported that s/he anticipated it being a consistent maintenance routine to ensure the area stayed clean. Administrator M reported s/he had noticed the missing kitchenette tile and the provider was currently waiting on a new one to be delivered. Regarding the kitchenette overhead fixture, Administrator M reported s/he would address the concern. Regarding the lightbulbs, Administrator M reported that after the

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{N 481}	Continued From page 193 onsite survey s/he had walked around the entire facility and ensured all lightbulbs were in working condition. Regarding Resident 13's outlet cover, Administrator M reported s/he had it fixed approximately a couple weeks ago. Summary: The provider did not ensure that the living environment was safe, clean, and homelike. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws	{N 481}		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 3 of the provider's semi-annual emergency or disaster evacuation drills from 01/01/2023 - 08/29/2024 (day of survey) were completed. The findings include: On 08/29/2024, Surveyor conducted a review of the provider's emergency and disaster evacuation drills for 2023 and 2024 to verify compliance with semi-annual emergency and disaster evacuation drill requirements. Surveyor requested all of the provider's emergency or disaster evacuation drills for 2023 and 2024 from House Manager B. The records consisted of tornado drills documented on 04/10/2023 and 08/26/2024.	N 526		

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N 526	Continued From page 194 There was no other drill documented for 2023. At approximately 10:30 a.m., Surveyor interviewed House Manager B. House Manager B confirmed s/he had no other emergency or disaster evacuation drill records. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws	N 526		
{N 612}	83.55(3) Bath and toilet areas: hand drying. Hand drying. All sink areas shall have dispensers for single use paper towels, cloth towel dispensing units that are enclosed for protection against being soiled or electric hand dryers. This requirement does not apply to sink areas located in toilet rooms accessed directly from a resident bedroom. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 4 of 4 of the provider's bathroom sink areas had dispensers being used for single use paper towels, cloth towel dispensing units enclosed for protection, or electric hand dryers. This requirement is being cited for the second time. See Statement of Deficiency (SOD) OCCY11, issued 06/17/2024. The findings include: On 08/29/2024, at approximately 7:50 a.m., Surveyor toured the provider's 3 resident bathrooms - marked as bathrooms "A" and "C", with the remaining bathroom unlabeled. The 3	{N 612}		

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resident bathrooms contained empty paper towel dispensers. Bathrooms A and C did not contain any other means for residents to dry their hands. The unmarked bathroom contained a hand towel which was laying on the sink counter.

At approximately 11:13 a.m., Surveyors observed the fourth bathroom, which was indicated for employee use (marked as bathroom "D"). The paper towel dispenser near the sink appeared to have a roll of paper towel, however, upon two Surveyors testing the dispenser, no paper towel came out. No sensor lights appeared to flash on the dispenser, so it was unclear whether the hand sensor was working. No other means of hand drying was observed in the bathroom.

At approximately 12:38 p.m., Surveyor observed the employee bathroom again, which contained a roll of paper towel placed on the sink counter. No other means of hand drying was observed in the bathroom.

At approximately 4:07 p.m., Surveyor observed the provider's 4 bathrooms again. The 3 resident bathrooms appeared unchanged in their hand drying means, with bathrooms A and C still observed with no means for hand drying and the unmarked bathroom observed with a towel placed on the sink counter with no other means for hand drying. The employee bathroom appeared to continue to not dispense paper towel when tested by Surveyor, and a roll of paper towel still sat on the sink counter.

At approximately 8:18 p.m., Surveyors interviewed House Manager B. House Manager B acknowledged and took notes of Surveyors' concerns regarding the bathroom hand drying areas but said nothing further.

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{N 612}	Continued From page 196 On 10/02/2024, at approximately 2:49 p.m., Surveyor interviewed House Manager B and Administrator M. Administrator M reported s/he was working on addressing the paper towel holders and had ordered new paper towel holders/dispensers. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws	{N 612}		
N 637	83.59(1)(g) Proper exit locations, sidewalks, driveways. All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exits, sidewalks and driveways used for exiting shall be kept free of ice, snow, and obstructions. For facilities serving only ambulatory residents, the CBRF shall maintain a cleared pathway from all exterior doors to be used in an emergency to a public way or safe distance away from the building. For facilities serving semi-ambulatory and non-ambulatory residents, a CBRF shall maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2 primary exits from the building. All other required exits shall have at least a cleared pathway maintained to a public way or safe distance from the building. An exit door or walkway to a cleared driveway leading away from the CBRF also meets this requirement.	N 637		

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This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure that sidewalks used for exiting were kept free from obstructions and had a clear pathway maintained to a safe distance from the building.

The findings include:

The facility is licensed to serve up to 16 non-ambulatory residents in the client groups of emotionally disturbed/mental illness, physically disabled, irreversible dementia/Alzheimer's, and advanced aged.

On 08/29/2024, Surveyors conducted a complaint investigation, verification visit, and standard licensing survey. Through observations of residents made that day while Surveyors were on site, approximately 7:41 a.m. until 9:30 p.m., Surveyors observed 9 residents, 6 of whom demonstrated the following ambulatory abilities:

- Resident 7: Utilized both a 4-wheeled walker and walked independently around the facility
- Resident 9: Utilized a manual wheelchair that s/he self-propelled with his/her feet to get around
- Resident 11: Utilized a power scooter to get around the facility
- Resident 12: Utilized a single point cane to ambulate around the facility
- Resident 4: Utilized a 4-wheeled walker to get around the facility
- Resident 2: Utilized a 4-wheeled walker to get around the facility

On 08/29/2024, at approximately 8:53 a.m., Surveyor observed the facility's exits. Two doors at the front of the facility, located approximately 2 feet away from each other, were at the front

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facility entrance (Photo 1). Two doors were observed opposite to the front entrances, across the facility dining and common areas. Both of those doors led to the same concrete patio and yard, which were enclosed by a fence (Photos 2-4). The patio extended only a few feet from the doors, but on one side connected to a sidewalk that went along the back of the building and around to the side. A gate, as part of the fence, was located at the back corner of the facility, blocking full egress away from the building. Upon observing the gate, Surveyor observed that the gate was unable to be opened from the fenced-in side, and that the mechanism to open the gate appeared to be on the outside of the fence/gate (Photo 5). Surveyor was unable to open the gate from the fenced-in side (where residents would be exiting from). Surveyor toured the facility and tested doors that were not labeled as resident bedrooms and the staff break room in order to see if there were any other exits from the building - all of which were locked.

At approximately 8:18 p.m., Surveyor interviewed House Manager B. House Manager B confirmed that the opening mechanism on the back gate was switched around so that it was on the outside of the fenced-in area as opposed to the inside of the fenced-in area. House Manager B reported this was done awhile ago due to Resident 10 having eloped from the back patio through that gate when s/he was alive, in order to prevent him/her from eloping. House Manager B acknowledged Surveyor's concern that the opening mechanism being on the outside of the gate prevented its use for egress and prevented the back doors from having a clear pathway to a safe distance away from the building.

Cross Reference:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017703	A. BUILDING: _____ B. WING _____	R-C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGES OF MADISON APPLEWOOD	5565 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 637	Continued From page 199 N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws	N 637		
N 640	83.59(2)(b) Solid core wood doors or equivalent A solid core wood door or an equivalent fire resistive door shall be provided at any interior stair between the basement and the first floor. The door shall have a positive latch and an automatic closing device and normally shall be kept closed. Enclosed furnace and laundry areas with self-closing doors in a split level home may substitute for the self-closing door between the first and second levels. Enclosed furnace and laundry areas shall have self-closing solid core wood doors or an equivalent fire resistive door when located on a common level with resident bedrooms. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 2 of 2 furnace rooms and 1 of 1 laundry rooms, which were all enclosed and located on a common level with resident bedrooms, had self-closing solid core wood or fire resistive doors. This requirement is being cited for the second time. See Statement of Deficiency (SOD) FT8K13, issued 08/23/2023. The findings include: On 08/29/2024, at approximately 7:57 a.m., Surveyor observed the provider's laundry room, which had 2 doors for entry, both located in hallways from where resident bedrooms were also located. One door appeared closed with a mechanism at the top of the door to allow for	N 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 640	Continued From page 200 self-closure. The other door was open. Surveyor tested the door, which appeared to hold at any position Surveyor put it in without self-closing. At approximately 10:03 a.m., Surveyor toured the provider's 2 mechanical rooms, where furnaces were located, with House Manager B. Both mechanical rooms were located in hallways from where resident bedrooms were also located. Both rooms had doors that did not self-close. Surveyor observed the laundry room again with House Manager B and interviewed him/her about the lack of self-closing doors for the provider's mechanical and laundry rooms. House Manager B acknowledged Surveyor's concern that the above rooms needed to have self-closing doors, but said nothing further. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Compliance With Laws	N 640		