STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019249	A. BUILDING: _____ B. WING _____	R-C 12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE SENIOR LIVING	3172 OLD TOWN ROAD EAU CLAIRE, WI 54701

(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 11/06/2023, Surveyor began a verification visit and complaint investigation at Cambridge Senior Living. Data was collected through 12/05/2023. Two of 3 complaints were substantiated. Two violations were identified. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 47.	{N 000}		
N 388	83.35(3)(c) Implement, follow the individual service plan 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 endure individual service plans were followed for 2 of 2 residents reviewed. The provider is licensed to care for 72 residents in the client groups advanced aged, irreversible dementia/Alzheimer's disease, and physically disabled. Resident 1 On 11/07/2023, Surveyor reviewed the records of Resident 1, admitted on 08/21/2023 and discharged on 10/19/2023. Resident 1 was diagnosed with unspecified dementia, unspecified severity, without behavioral disturbance, type 1 diabetes mellitus with diabetic chronic kidney disease, type I diabetes mellitus with hyperglycemia, atherosclerotic heart disease, acute on chronic combined systolic and diastolic	N 388		

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

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heart failure, and major depressive disorder. Resident 1 had an activated power of attorney and was enrolled in hospice.

On 11/06/2023, from 1:12 PM to 1:42 PM, Surveyor interviewed Hospice Nurse (HN) A. HN A stated Resident 1's family reported they were not happy with the care Resident 1 received. HN A stated Resident 1 was diabetic and required toileting assistance. HN A stated Resident 1 was found often in soaked briefs, clothing, and bedding. HN A stated that on 2 occasions, s/he found Resident 1 soaked in urine from head to toe when s/he arrived at the facility in the morning. HN A stated that on another occasion, s/he noted a urine smell in the room and discovered Resident 1's bed comforter was covering a wet soaker pad and wet bed sheets. HN A stated staff called hospice 5-6 times a month asking for assistance and guidance when Resident 1's blood sugar was high despite the orders in the medication administration record (MAR). HN A stated it was disappointing staff were not meeting Resident 1's needs. HN A stated s/he observed staff transfer Resident 1 multiple times without a gait belt. HN A stated cares improved after a care conference when 2-hour toileting and 1-hour safety checks were implemented.

At approximately 3:30 PM, Surveyor interviewed Clinical Care Assistant (CCA) C. CCA C stated staff had a difficult time administering Resident 1's Novolog (insulin). CCA C stated staff were to administer Novolog if s/he ate 50% of his/her meal but the MAR had the time of administration at 4:00 PM, which was before s/he ate supper. CCA C stated that if Resident 1's blood sugar was over 400 we would call hospice and they would come into the facility to assist. CCA C stated s/he

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observed that at times staff did not use a gait belt with Resident 1 and s/he was often found soaked in urine from head to toe.

On 11/07/2023 at approximately 12:35 PM, Surveyor interviewed CCA F. CCA F stated it was hit and miss whether or not Resident 1 was dry in the morning and s/he assumed the night shift was not changing him/her.

On 11/13/2023, from 2:56 PM to 3:47 PM, Surveyor interviewed Power of Attorney (POA) J. POA J stated that on 08/24/2023, s/he was visiting Resident 1. POA J stated Resident 1 was in the dining room eating breakfast when POA J heard yelling from the dining room. POA J stated s/he found Resident 1 on the dining room floor, bleeding. POA J stated Regional Director (RD) K told him/her that there should have been someone in the dining room during mealtime. POA J stated s/he had witnessed staff on at least 5 occasions transfer Resident 1 without a gait belt. POA J stated that despite Resident 1 being on 2-hour toileting checks, s/he was found soaked on many occasions. POA J stated that on 09/24/2023 at approximately 12:30 PM, s/he visited and found Resident 1 soaked from head to toe. POA J stated s/he asked CCA D about this and CCA D stated staff had been very busy and s/he was unsure the last time Resident 1 had been toileted or checked on because staff do not chart completed cares until the end of their shifts. POA J stated that on 09/15/2023, s/he found Resident 1 soaked at 5:00 PM and staff reported s/he had not been changed since lunch. POA J stated that on 09/14/2023, s/he found Resident 1 very wet in the AM and, when s/he asked staff about this, CCA N stated they were short-staffed.

On 11/17/2023, from 9:33 AM to 9:46 AM,

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N 388	Continued From page 3 Surveyor interviewed Managed Care Social Worker (MCSW) I. Resident 1 enrolled in managed care after his/her admission. MCSW I stated the provider did not appear to have enough staff to complete cares and, when questioned, would respond they would try harder. MCSW I stated the provider had indicated they were fully staffed. On 11/28/2023, Surveyor reviewed CASE NOTE DETAILS from Resident 1's managed care organization that included: -"08/24/2023 ...[POA] indicated member just had a fall this morning and hit [his/her] head. -09/29/2023 ...Report [s/he] spoke with [Administrator G] ...inquired on member..[s/he] asked to be changed every 4 hours and hospice stated no, [s/he] needs to be toileted/changed every 2 hours. -10/02/2023 ...[POA J] reviewed ongoing issues with member incontinence and not being changed timely, call light response ...Manager on Call [sic] phone not being answered ... -10/13/2023 ...[POA J] noted that the 30 minute checks log on bathroom door had already had the 8:30am checked off prior to when [s/he] arrived (which was before 8:30am}. On 12/04/2023, Surveyor reviewed email documents received from POA J that included: -" ...I spoke with [RD K] on 8-24 when [Resident 1] experienced [his/her] fall. [RD K] reported it's their policy to have staff in the dining room when residents are eating. -09/24/2023 ...We smelled urine and asked [Resident 1] if [s/he] had been to the bathroom recently. We pulled [his/her] lap blanket back and found [s/he] was soaked from [his/her] midriff to [his/her] toes with urine and BM [bowel movement].	N 388		

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N 388	Continued From page 4 -09/24/2023 ...[Resident 1] had a blood sugar of 550+. Hospice was trying to reach the facility but was unable. -10/07/2023 ...Upon arrival at 3pm to visit [Resident 1] this afternoon, [Resident 1] was hanging off the front of [his/her] recliner using [his/her] legs to hold [him/her] up ...Next to [him/her] was [his/her] lunch tray ...with [his/her] lunch tray next to [him/her] leads us to believe [s/he] may not have been checked on for quite a while ....we pushed [Resident 1's] call button at approximately 3:50pm [sic] because we could smell BM ...we waited 15 minutes with no response ...we toileted [him/her] ourselves. [Resident 1] was again caked with BM down [his/her] legs ...Staff responded to [Resident 1's] call ...40 minutes after pushing ...We pulled [Resident 1's] bedding back to find a dirty soaker pad atop [his/her] sheets and under [his/her] bedspread. -10/13/2023 ...We visited last night around 8p [PM]. [Resident 1] was quite wet ...Charting says [s/he] was dry since 12p [PM]. -10/13/2023 ...[Resident 1] was not getting assistance with eating even though there were two staff in dining room sitting." -On 09/22/2023, an email from provider to POA J read, " I know you are concerned with [Resident 1] not being changed and soaking through [his/her] clothes. I feel like lately we have had a better routine ...[S/he] is on a two-hour toileting schedule. If you come in after hours and see [s/he] is soaked though, please contact the manager on duty ...It was mentioned that you have concerns regarding insulin and blood sugars. [Resident 1's] orders are written very clearly, but we are doing a staff education on [his/her] insulin/blood sugar/Dexcom (continuous glucose monitoring system) to make sure staff	N 388		

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N 388	Continued From page 5 have a complete understanding." -On 10/09/2023 an email from provider to POA J read, "Two hour-Toileting [sic] was missed at shift change." POA J stated that during a care conference with RD K and Administrator G they said they would ensure Resident 1's 2-hour toileting would improve. POA J stated s/he asked CCA F how often Resident 1 was changed at night and his/her response was, "I don't even know if [s/he] is being checked on every 2 hours." On 11/07/2023, Surveyor reviewed Resident 1's Individualized Service Plan (ISP), last updated on 09/22/2023. The ISP included: -"Mobility ...Staff is to use a hoyer [sic] lift if resident is weak and unable to stand. If resident is at baseline, utilize gait belt with staff assistance with pivot transfers. -Eating/meals ...[Resident 1] should not be unsupervised in the dining room. -Toileting/bowel/bladder ...[Resident 1] is on a 2 hour toileting schedule. -Medications ...[Resident 1] has a Dexcom to monitor [his/her] blood sugar. Family has set up an app on [his/her] Ipad [sic] that when [his/her] blood sugar is low, the app will continue to alarm until [his/her] blood sugar increases ...Staff should ensure [his/her] cell phone is with [him/her] as this is what sends [his/her] Dexcom reading to [his/her] tablet. -Behaviors ...Other: 30 minute [sic] checks initiated temporarily to align with resident change in condition. -Falls ...09.04.23// [sic] Unwitnessed fall: no injury. Resident will be reminded to use call	N 388		

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pendant. 09.17.23// [sic] Unwitnessed fall; no known injuries; Staff to make sure residents walker is within reach. 09.18/23// [sic] Unwitnessed fall, no known injuries; Staff [sic] will wake resident and toilet on overnights. Safety Checks for Falls: Every 2 hours."

Resident 2
On 12/04/2023, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 04/04/2023 and discharged 10/24/2023. Resident 2 was diagnosed with vascular dementia, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, hypothyroidism, depression, cerebral infarction, and chronic obstructive pulmonary disease. Resident 2 had an activated POA.

On 11/06/2023, from 1:12 PM to 1:42 PM, Surveyor interviewed HN A. HN A stated Resident 2 was moved by family from the facility because s/he was not receiving adequate care, did not consistently receive feeding assistance, and pro re nata (as needed) medication for constipation was not administered. HN A stated the provider was not tracking bowel movements and HN A had to physically remove the fecal impaction on 2 occasions because staff did not administer PRN medication.

On 12/04/2023, from 10:18 AM to 11:35 PM, Surveyor interviewed POA L. POA L stated s/he observed CCA M use a pivot transfer with Resident 1. POA L stated s/he had discussed this with Administrator G. POA L stated s/he had observed, on 2 occasions, Resident 2 at breakfast sitting in front of a plate of food without staff in attendance. POA L stated s/he had observed on 2 occasions staff give Resident 2 a

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fork full of food, walk away, and return later to give another fork full. POA L observed approximately 5 times Resident 2 left alone in the bathroom. POA L indicated s/he was informed of 3 falls and 1 incident when Resident 2 passed out when on the toilet. POA L indicated that bowel movements for Resident 2 were not being tracked and subsequently PRNs were not utilized for constipation.

On 12/05/2023, Surveyor reviewed a hospice progress note, dated 10/04/2023, that read, "[Resident 2] had diarrhea x 2 days, Loperamide given and effective." A progress note, dated 10/09/2023, read, "[Resident 2] has had no BM [bowel movement] x 3 days. Miralax given." Surveyor reviewed the medication administration record (MAR) and found 3 pro re nata constipation medications and 1 PRN diarrhea medication were listed but none had been administered.

On 12/05/2023, Surveyor reviewed documents that included information on 2 falls. The first occurred 05/02/2023 and included, "..Unwitnessed fall ...resident was laying o [his/her] right side with [his/her] w/c [wheelchair] on its side ...due to resident hitting [his/her] head, resident was sent out to the hospital. Immediate Action: Resident was given a wrist call pendant instead of a lanyard so it is easier to access."

The second fall occurred on 06/19/2023 and notes included, " ...staff walked into room and observed [Resident 2] on the floor in front of [his/her] recliner, with the recliner in an elevated position. Staff noted [Resident 2] was in visible and audible pain, as well as a bump on [his/her] head and blood on the floor."

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N 388	Continued From page 8 On 11/07/2023, Surveyor reviewed Resident 2's ISP, last updated on 05/04/2023. The ISP included: -"Eating/meals ...Staff will physically assist [Resident 2] with eating. -Toileting/bowel/bladder ...Staff will provide physical assistance during toileting. Can not [sic] be left unattended in the bathroom or on the toilet due to history of syncopal episode. [S/he] needs supervision while in the bathroom on the toilet at all times. -Mobility ...Staff will provide full assistance during mobility ....[Resident 2] requires a sit to stand for transfers to/from destination. -Falls...Remind to call for assistance." A handwritten entry read, "Updated 5/2 1 fall tipped from wheelchair." Surveyor reviewed Resident 2's ISP, dated 09/22/20233, and observed there was not a Falls section. The provider did not implement Resident 1 and Resident 2's ISPs.	N 388		
N 430	83.38(1)(f) Communication skills. 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: Communication skills. The CBRF shall provide services to meet the resident ' s communication needs. This Rule is not met as evidenced by:	N 430		

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N 430	Continued From page 9 Based on record review and interview, the provider did not arrange adequate services to meet the residents' communication needs. Findings include: The Department received a complaint regarding the provider's phone system. The provider is licensed to care for 72 residents in the client groups advanced aged, irreversible dementia/Alzheimer's disease, and physically disabled. On 11/06/2023 at approximately 10:00 AM, Surveyor interviewed Administrator G. Administrator G stated a new phone system was installed on 10/09/2023 and when a call comes into the building, Monday through Friday during daytime hours, it is routed from the front desk receptionist to the correct staff. Administrator G stated all phone calls that come in after hours and on the weekends are routed to the staff work phones that all staff carry. Administrator G stated that in the event a call went to voicemail after hours and on the weekend, the message now included a phone number to contact the manager on duty. Administrator G stated that prior to 10/09/2023, s/he had received complaints from hospice and family that phone calls were not returned, especially after hours. Administrator G stated that prior to 10/09/2023, the phone system had not worked well for a couple months but s/he had not received any complaints since the new system was installed. On 12/04/2023, from 12:08 PM to 12:42 PM, Surveyor interviewed Administrator G. Administrator G stated that prior to 10/09/2023, the provider was unable to get phone calls to	N 430		

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transfer to the staff handheld phones. Administrator G stated staff could give the residents their handheld phones for calls. Administrator G stated there was probably a time when callers were unable to leave a voicemail with the on-call manager.

On 11/06/2023 from 1:12 PM to 1:42 PM, Surveyor interviewed Hospice Nurse (HN) A. HN A stated there had been issues with the facility phone system. HN A stated that sometimes during the day and especially at night and weekends, calls went into an automated system. HN A stated there were several incidents of attempting to contact the provider in the evening and overnight, but s/he was not able to reach anyone and did not receive a response to his/her voicemail. HN A stated facility staff would call the triage hospice nurse and leave a message but when hospice returned the call, hospice could not reach staff at the facility, and this led to hospice having to travel to the facility to provide resident assistance.

On 11/13/2023, from 2:50 PM to 3:47 PM, Surveyor interviewed Power of Attorney (POA) J. POA J is the POA for Resident 1. POA J stated s/he had received calls from staff from unidentified numbers and assumed staff were using their personal cell phones. POA J stated s/he knew staff were utilizing their personal phones to call HN A with hospice questions. POA J stated that on 09/10/2023, at approximately 7:30 PM, s/he left a message regarding Resident 1's elevated blood sugar (monitored on POA J's phone app) but s/he did not receive a return call. On 09/14/2023, s/he called to schedule a hair appointment for Resident 1 and did not receive a return call. POA J stated the manager's phone number was listed in the voicemail but when s/he

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called there was no option to leave a voicemail. POA J stated his/her concerns were brought up in a care conference and s/he inquired if staff knew how to access voicemails and if they were checking for messages.

POA J stated Resident 1 did have a phone in his/her room, but s/he no longer could use it on his/her own. POA J stated s/he was not aware there was a cordless phone provided for the residents to receive or make calls.

On 11/17/2023, from 9:33 AM to 9:46 AM, Surveyor interviewed Managed Care Social Worker (MCSW) I, Resident 1's case manager, who stated s/he could not always reach someone at the facility during the day and heard reports from Resident 1's hospice team that they were unable to reach anyone by phone.

On 11/06/2023 at approximately 2:30 PM, Surveyor interviewed Clinical Care Assistant (CCA) B. CCA B stated many residents have their own phones. CCA B stated s/he had no understanding of how residents were to use the facility phone if needed. CCA B stated, "I would imagine there is a cordless phone."

At approximately 3:45 PM, Surveyor interviewed CCA C. CCA C stated that if residents received a call on the facility phone, there was not a cordless phone to give them. CCA C stated that at times, staff were letting the residents use their personal cell phones.

On 11/07/2023 at approximately 12:05 PM, Surveyor interviewed CCA E. CCA E stated that since the new phone system was installed, the call transfers to the staff handheld phones when in the front desk does not answer. CCA E stated

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CAMBRIDGE SENIOR LIVING	3172 OLD TOWN ROAD EAU CLAIRE, WI 54701

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N 430	Continued From page 12	N 430		

it is possible for the residents to talk on the staff handheld phones.

At approximately 12:35 PM, Surveyor interviewed CCA F. CCA F stated there were multiple complaints from Resident 1's family about the phone system.

On 12/04/2023 from 10:18 AM to 11:35 PM, Surveyor interviewed POA L, the POA for Resident 2. POA L stated s/he stopped calling the provider because s/he could rarely get hold of anyone. POA L stated the phone tree would send the call to an extension and then disconnect the call. POA L stated that during business hours, at night, and on weekends, calls often did not reach a person and when s/he was able to leave a voicemail, no one would respond. POA L stated that they were not aware of a phone available for residents. POA L stated s/he heard a staff say the phone rang all the time and they were not going to answer it.

On 11/29/2023, Surveyor reviewed a document titled ADMISSION AGREEMENT & RESIDENT HANDBOOK RESOUCE GUIDE [FACILITY NAME] VERSION 9-7-2022. Under the category RESIDENT RIGHTS it read, "Make and receive telephone calls within reasonable limits and in privacy. The CBRF [community based residential facility] shall provide at least one non-pay telephone for resident use." Under TELEPHONE it read, " ...Please contact [facility name] Administration for further information on options and available plans through a local provider."

On 12/05/2023, Surveyor reviewed a document titled [FACILITY NAME] POLICIES AND PROCEDURES PERSONAL CELL PHONE, dated 10/2020 that read, " ...Personal cell phone

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	0019249	A. BUILDING: _____ B. WING _____	R-C 12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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use on the floor while clocked in for a shift is strictly forbidden ...personal cell phones may only be used while in the Employee Breakroom ...personal cell phones should never be seen in the following locations:
Medication Rooms
Resident Rooms
Laundry Rooms,
On the floor while providing cares."

On 11/29/2023, Surveyor reviewed email documents from POA J that included:
-"On 9-6. I have text messages to [HN A]. I tried to contact the facility as [Resident 1's] sugar was reading 50. No answer. [HN A], was able to get ahold [sic] of [staff] at facility. [HN A] reported [s/he] spoke to management about concerns about inability to get ahold [sic] of staff.
-I also received a call from a staff member when [Resident 1] fell with (what I assume to be) [his/her] personal cell.
-We feel like if we want to know how [Resident 1] is doing we cannot simply call but have to drive to the facility."

On 11/29/2023, Surveyor reviewed an email communication, dated 09/22/2023, from Regional Director (RD) K to POA J that read, "Regarding the phone systems, we know they are frustrating. During business hours, we do have someone at the front desk 8:30-5:00 PM who answers the phone and checks messages. We have educated management to check their voicemails and return calls within 24 hours unless it is a weekend. We have been working on getting a completely new phone system ...in which there will be options to contact floor staff. If you have concerns during the day or weekend ...would you be comfortable sending an email to [Administrator G]?...Otherwise, staff have ringcentral (a phone

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N 430	Continued From page 14 system), on their phones and if [Resident 1] wants to call you [s/he] can absolutely use that. If it is in emergency, you can always call the Manager on Duty [sic] and there is a voicemail set up on that phone now." The provider did not arrange adequate services to meet the residents' communication needs.	N 430		