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	0017918	A. BUILDING: _____ B. WING _____	R-C 03/21/2024

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{N 000}	Initial Comments On 01/24/2024, with information gathered through 02/02/2024, Surveyors conducted a verification visit and 6 complaint investigations; on 03/14/2024, with additional information gathered through 03/21/2024, Surveyors conducted 3 new complaint investigations and a self-report investigation at Apple Creek Place III. Seven of 9 complaints were substantiated. Eighteen deficiencies were identified. Ten of 18 deficiencies were repeat violations. See Statements of Deficiency (SOD) F8JP11, dated 01/21/2021, SOD P4Z911, dated 01/17/2022 and SOD P4Z912, dated 09/26/2023. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 18	{N 000}		
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 observation and interview, the provider did not immediately notify Resident 3, Resident 4, Resident 10, and Resident 11's legal representatives and physicians when there was	N 169		

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

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an incident, injury, and significant change in the residents' conditions.

This is a repeat deficiency, see Statement of Deficiency (SOD) P4Z911, dated 01/17/2022.

Findings include:

On 03/14/2024, Surveyors conducted complaint and self-report investigations.

On 03/05/2024, the department received complaint information alleging 5 residents were hit and injured by another resident.

On 03/04/2024, the department received self-report information from Administrator RN B. The report stated on 03/01/2024 at approximately 4:00 AM, Resident 4 had gone into Resident 10's room and stole his/her remote. Resident 10 followed Resident 4 to the common area and they started fighting. Resident 10 hit Resident 4 on the side of his/her face and s/he fell to the floor. Resident 11 got up to defend Resident 4 and s/he was struck in the left eye. Staff separated resident. Residents were escorted back to their rooms. Administrator RN B was notified in the morning and assessed residents. Resident 4 and resident 10 did not have any injuries. Resident 11 had a black and blue left eye.

On 03/14/2024, Surveyor reviewed Resident 4, Resident 10, and Resident 11's records.

Resident 4
Surveyor noted Resident 4 had diagnoses of alzheimer's disease, anxiety, and heart disease. Surveyor reviewed Resident 4's incident report dated 03/01/2024 completed by Caregiver K which stated, "I seen [saw] [Resident 4] getting hit

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at a rapid pace in the face at the time my back was turn [sic] doing 2 hour checks when I got back to common area [Resident 4] was on the ground crying. I help [sic] [Resident 4] back to [his/her] room but [s/he] was scared stayed in [his/her] room the whole night." Surveyor noted the incident report listed "Physician Notified?" and "Resident's family or representative notified?" with a filled check box next to "No" for both questions.

Resident 10
Surveyor noted Resident 10 had diagnoses of bipolar disorder II, tardive dystonia, and central pontine myelinolysis.
Surveyor reviewed Resident 10's incident report dated 03/01/2024, completed by Caregiver K which stated "resident said [s/he] was sleep walking don't remember attacking people. I heard a lot of screaming yelling when I arrive [sic] in the common area it was a brawl with 3 other [identified gender] residents. It last [sic] for about 2 minutes. I separated all of the residents that were involved no other alterations [altercations] occurred the rest of the night." Surveyor noted the incident report listed "Physician Notified?" and "Resident's family or representative notified?" with a filled check box next to "No" for both questions.

Resident 11
Surveyor noted Resident 11 had diagnoses of vascular dementia, anxiety, insomnia, and aphasia.
Surveyor reviewed Resident 11's incident report dated 03/01/2024 completed by Caregiver K which stated "[Resident 11] could not tell me what happened. The resident was hit in the face started to fight back with [Resident 10] my back was turn [sic] when I was doing 2 hour check

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caught [him/her] tussling with [Resident 10] [s/he] did defend [his/herself] by throwing punches back." Surveyor noted the incident report listed "Physician Notified?" and "Resident's family or representative notified?" with a filled check box next to "No" for both questions.

On 03/18/2024 at 7:00 PM, Surveyor interviewed Family Member N. Family Member N verified s/he was the HCPOA (Health Care Power of Attorney) for Resident 4. Family Member N indicated s/he was never made aware of any incidents where Resident 4 was physically hit by another resident. Family Member N indicated the facility has called him/her when Resident 4 had fallen, was sexually assaulted by another resident and had a change in condition, but was never notified of any physical altercation with another resident at the facility.

On 03/19/2024 at approximately 5:00 PM, Surveyor interviewed Power of Attorney for Healthcare (POAHC) EE who verified s/he was Resident 10's POAHC. POAHC EE reported s/he was told the "supposed" incident happened around 4:00 AM on 03/01/2024, but s/he was notified on his/her voicemail at 7:00 AM by a staff member who did not witness the incident. POAHC EE stated it was not immediate and the voicemail was "very off-putting" and didn't provide any information. POAHC EE stated s/he still doesn't know if it even actually happened as s/he keeps hearing different stories. POAHC EE stated this would be a big change for Resident 10 as s/he had never been physical towards others before.

On 03/18/2024 at approximately 3:30 PM, Surveyor interviewed POAHC FF who verified s/he was Resident 11's POAHC. POAHC FF

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N 169	Continued From page 4 reported not being aware of or notified of the incident on 03/01/2024 and that Resident 11 sustained a black eye. On 03/14/2024, 03/18/2024, and 03/19/2024, Surveyors requested documentation of notification to Resident 4, Resident 10 and Resident 11's physicians regarding the incident and no documentation was provided. On 03/21/2024 at approximately 8:30 AM, Surveyors interviewed Director A and Regional Director of Operations Y. On 03/21/2024 at approximately 8:30 AM, Surveyors interviewed Director A and Administrator RN B. Director A stated Resident 3 was the third person involved in the altercation involving Resident 10, but s/he did not sustain any injury. Director A verified there was no documentation of Resident 3's involvement in the incident and his/her legal representative was not notified of the incident. Director A and Administrator RN B acknowledged Resident 4, Resident 10, and Resident 11's legal representatives were not immediately notified following the incident. Director A and Administrator RN B acknowledged Resident 10 and Resident 11's physician was not immediately notified following the incident. Cross Reference: N0426 DHS 83.38(1)(b) Supervision N0433 DHS 83.38(1)(i) Behavior Management	N 169		
{N 196}	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its	{N 196}		

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{N 196}	Continued From page 5 operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. Seven of 9 complaints investigated from 01/24/2024 through 03/21/2024 were substantiated; and 19 deficiencies were identified, including 10 repeat violations. See Statements of Deficiency (SOD) SOD F8JP11, dated 01/21/2021, SOD P4Z911, dated 01/17/2022 and SOD P4Z912, dated 09/26/2023. This is a repeat deficiency, see Statement of Deficiency (SOD) P4Z912, dated 09/26/2023. Findings include: The provider is licensed to serve up to 22 residents who may be physically disabled, of advanced age, terminally ill, and/or have Alzheimer's/dementia. On 01/24/2024, Surveyors conducted a verification visit. At approximately 9:05 AM, Surveyors interviewed Director A and notified him/her they were conducting a verification visit and complaint investigation. Director A stated s/he started in November 2023, but s/he was aware of the past SOD and the special orders and that it was in a binder near the entrance. Director A stated, "We [management team] meet on it weekly." Surveyor inquired if they had documentation of the discussions held that s/he could provide to Surveyors and Director A said	{N 196}		

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{N 196}	Continued From page 6 yes. On 01/24/2024, Surveyor reviewed SOD P4Z912 dated 09/26/2023, and noted special orders related to the development, implementation, and training of procedures for health monitoring (including physical and mental health), change in condition, adequate treatment, and activity programming. On 01/24/2024 at approximately 2:38 PM, 01/25/2024 at 12:56 PM, 01/29/2024 at 8:40 AM, and 01/30/2024 at 8:45 AM, Surveyors requested a copy of documentation Director A referenced as follow up from the previous SOD and special orders. On 01/31/2024 at approximately 11:00 AM, Surveyors interviewed Director A and Administrator RN B. Director A stated s/he was not aware of the previous SOD and that s/he was only aware of the sister facility's SODs, so did not have any documentation and follow up for the verification visit. Director A and Administrator RN B acknowledged licensee responsibilities were not upheld. On 03/14/2024, Surveyors conducted 3 new complaint investigations and a self-report investigation. On 03/21/2024 at approximately 8:30 AM, Surveyors interviewed Director A and Administrator B. Surveyors inquired with Director A and Administrator B whether they received training in recognizing and reporting abuse, neglect and misappropriation, and in resident rights. Director A stated s/he did not. Administrator B stated s/he did not.	{N 196}		

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{N 196}	Continued From page 7 On 03/21/2024 at approximately 1:00 PM, Surveyors interviewed Regional Director Y who verified Licensee H acknowledged awareness of the invites to the exit conferences on 01/31/2024 and 03/21/2024, and the findings from the investigations. At the time of investigations, the census was 18 residents. As a result of Licensee R not upholding his/her responsibilities as the licensee, 7 of 9 complaints investigated from 01/24/2024 through 03/21/2024 were substantiated and the following 19 deficiencies were identified (10 of 19 deficiencies were repeat violations): N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws Based on observation, record review, and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. This is a repeat deficiency, see SOD P4Z912 dated 09/26/2023. N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes Based on observation and interview, the provider did not immediately notify Resident 4, Resident 10, and Resident 11's legal representatives and physicians when there was an incident, injury, and/or significant change in the residents' conditions. This is a repeat deficiency, see Statement of Deficiency (SOD) P4Z911, dated 01/17/2022. N0223 DHS 83.18(1) Employee Records Maintained And Current Based on record review and interview, the provider did not ensure a separate record for 4 of 4 (Director A, Caregiver C, Caregiver E, and Caregiver I) employees reviewed was maintained and kept current.	{N 196}		

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{N 196}	Continued From page 8 N0230 DHS 83.19 Orientation Based on record review and interview, the provider did not ensure Director A and Caregiver I obtained orientation training prior to performing any job duties. This is a repeat deficiency, see Statement of Deficiency (SOD) F8JP11, dated 01/21/2021. N0243 DHS 83.21(1)-(3) All Employee Training Based on record review and interview, the provider did not ensure 2 of 2 of employee records (Director A and Caregiver I) reviewed, obtained all training as required within 90 days after starting employment. N0247 DHS 83.22(1)-(4) Task Specific Training Based on record review and interview, the provider did not ensure 2 of 2 of employee records reviewed (Director A and Caregiver I), obtained all task specific training. This is a repeat deficiency, see Statement of Deficiency (SOD) F8JP11, dated 01/21/2021. N0301 DHS 83.28(3) Provide Admission Agreement As Required Based on record review and interview, the provider did not ensure an admission agreement was given in writing and explained orally to the prospective resident or legal representative for 1 of 1 (Resident 8) residents reviewed. Resident 8 moved over from the sister facility across the street. Facility staff did not have Resident 8 or Resident 8's legal representative complete and review an admission agreement. N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment Based on record review and interview, the provider did not ensure 2 of 2 (Resident 3 and 4)	{N 196}		

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residents reviewed were free from physical and sexual abuse. On 03/06/2024, Resident 8 was found in Resident 4's bed. Resident 8's pants were down, Resident 4's top was off and side of brief was torn. Resident 8 was attempting to perform a sexual act with Resident 4. Additionally, on 03/06/2024, Resident 8 pushed Resident 3 to the floor in the common living room space.

N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan
Based on record review and interview, the provider did not develop a comprehensive individual service plan (ISP) for Resident 1 and Resident 5. This is a repeat deficiency, see Statement of Deficiency (SOD) F8JP11, dated 01/21/2021.

N0388 DHS 83.35(3)(e) Implement, Follow the Individualized Service Plan
Based on record review and interview, the provider did not implement and follow the ISP (Individual Service Plan) for 1 of 1 (Resident 2) residents reviewed.

N0426 DHS 83.38(1)(b) Supervision
Based on observation, record review, and interview, the provider did not provide supervision to Resident 2, Resident 4, Resident 5, and Resident 6 to meet their needs. This requirement is being cited for a third time. See SOD P4Z911, dated 01/17/2022 and SOD P4Z912, dated 09/26/2023

N0427 DHS 83.38(1)(c) Leisure Time Activities
Based on observation, record review and interview, the provider did not provide a daily activity program to meet the interests and capabilities of the residents. While present at the facility from approximately 8:30 AM to 1:00 PM

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and 1:45 PM to 4:00 PM, Surveyors did not observe residents engaged in activities and staff providing activities. This is a repeat deficiency. See Statement of Deficiency (SOD) P4Z912, dated 09/26/2023.

N0433 DHS 83.38(1)(i) Behavior Management
Based on record review and interview, the provider did not provide services to manage behaviors that my be harmful to themselves or others for Resident 7, Resident 8, and Resident 10.

N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable
Based on observation and interview, the provider did not provide a living environment that was safe, clean, comfortable and homelike. This is a repeat deficiency, see Statement of Deficiency (SOD) P4Z912, dated 09/26/2023.

N0499 DHS 83.45(3) Toxic Substances
Based on observation and interview, the provider did not ensure cleaning compounds, polishes, and toxic substances were labeled and stored in a secure area. This is a repeat deficiency, see Statement of Deficiency (SOD) P4Z912, dated 09/26/2023.

N0526 DHS 83.47(2)(e) Other Evacuation Drills
Based on record review, the provider did not ensure tornado, flooding, or other emergency or disaster evacuation drills were conducted at least semi-annually in 2023. This is a repeat deficiency, see Statement of Deficiency (SOD) P4Z912, dated 09/26/2023.

N0654 DHS 83.59 (4)(f) Delayed Egress Department Approval
Based on observation, interview, and record

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{N 196}	Continued From page 11 review, the provider did not demonstrate to the department the delayed egress equipment was necessary to ensure the safety of the residents served by the CBRF and obtain department approval for delayed egress doors. Y3244 Wis. Stat. Ch 50.09(1)(L) Care Based on observation, record review, and interview, the provider did not ensure Resident 10, Resident 11, and Resident 12 received adequate and appropriate care within the capacity of the facility.	{N 196}		
N 223	83.18(1) Employee records maintained and current. A separate record for each employee shall be maintained, kept current, and at a minimum, include: (a) Written job description including duties, responsibilities and qualifications required for the employee; (b) Beginning date of employment; (c) Educational qualifications for administrators; (d) Completed caregiver background check following procedures under s. 50.065, Stats., and ch. HFS 12; (e) Documentation of training, or exemption verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a separate record for 4 of 4 (Director A, Caregiver C, Caregiver E, and Caregiver I) employees reviewed was maintained and kept current. Caregiver C was hired on 12/28/2023. Caregiver C's employee record did not contain a complete DOJ (Department of Justice) and IBIS (Integrated	N 223		

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Background Information Systems) background check, RN (Registered Nurse) delegation paperwork, and all necessary orientation training requirements.

Caregiver E was hired on 07/06/2023, terminated (date unknown), and rehired 12/10/2023. Caregiver E's employee record did not contain a reason for termination or an investigation as to the reason for termination, RN delegation paperwork and all necessary orientation training requirements.

Findings Include:

On 01/10/2024 the department received a complaint regarding an allegation of employee abuse and no employee training.

On 01/24/2024, Surveyors conducted an onsite visit. Surveyor conducted employee record reviews, including the employee records of Caregiver C and E.

On 03/21/2024, Surveyors reviewed Director A and Caregiver I's employees records.

Caregiver C
Caregiver C was hired on 12/28/2023. A review of Caregiver C's background check information, Surveyor discovered Caregiver C's DOJ and IBIS report did not include the first page with the date the report was generated. Additionally, Caregiver C's employee record did not contain RN delegation papers. Surveyor reviewed Caregiver C's training record and discovered Caregiver C did not received orientation training related to emergency procedures, needs and services of each resident, and change in condition. On 01/24/2024, Surveyor requested the missing

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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 223	Continued From page 13	N 223		

documentation from Director A.

On 01/25/2024 at approximately 1:00 PM, Surveyor emailed Director A requesting the documentation again. Surveyor did not receive the documentation.

On 01/29/2024 at approximately 8:45 AM, Surveyor emailed Director A requesting the documentation again. Surveyor did not receive the documentation.

On 01/29/2024 at approximately 2:20 PM, Surveyor interviewed Director A. Surveyor requested the documentation, including all training Caregiver C received since hire. Surveyor did not receive the documentation.

On 01/30/2024 at approximately 8:45 AM, Surveyor emailed Director A requesting the documentation again. Surveyor did not receive the documentation.

On 01/31/2024 at approximately 11:00 AM, Surveyor interviewed Director A and Administrator/RN B. Director A acknowledged s/he did not have the first page showing the date the DOJ and IBIS were generated. Additionally, Director A indicated s/he sent all training documentation to Surveyor. Director A acknowledged Caregiver C did not have documentation of emergency preparedness, needs and services of residents and change in condition training before working the floor. Administrator/RN B indicated s/he did provide delegation training to Caregiver C, however, did not sign the paperwork indicating s/he did the training. Administrator/RN B stated s/he would send the signed paperwork by the end of the day.

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N 223	Continued From page 14 As of 02/01/2024, Surveyor did not receive the RN delegation paperwork. Caregiver E Caregiver E was hired on 07/06/2023 and rehired on 12/10/2023. Caregiver E's employee record did not contain information related to the reason for termination. Caregiver E's employee record did not contain RN delegation papers. Surveyor reviewed Caregiver E's training record and discovered Caregiver E did not received orientation training related to emergency procedures, needs and services of each resident, and change in condition. On 01/24/2024, Surveyor requested the missing documentation and any investigations into Caregiver E due to termination from Director A. On 01/24/2024 at 3:15PM, Surveyor interviewed Caregiver E. Caregiver E stated former director "let [him/her] go for no reason." Caregiver E stated it happened beginning of November 2023 and that former director stated it was about an allegation a resident made about Caregiver E. Caregiver E denied any wrongdoing and stated the resident had the wrong caregiver. Caregiver E stated the resident said Caregiver E said, "if you can wheel yourself down, you can wheel yourself back." Caregiver E denied saying this and implicated another caregiver who no longer works at the facility. On 01/25/2024 at approximately 1:00 PM, Surveyor emailed Director A requesting the documentation and investigation into Caregiver E. Surveyor did not receive the documentation. On 01/29/2024 at approximately 8:45 AM, Surveyor emailed Director A requesting the documentation again. Surveyor did not receive	N 223		

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N 223	Continued From page 15 the documentation. On 01/29/2024 at approximately 2:20 PM, Surveyor interviewed Director A. Director A stated s/he was unable to find anything in Caregiver E's file but sent an email to human resources asking if they had an investigation into Caregiver E. Surveyor requested all training Caregiver E received since hire. Additionally, Surveyor requested the RN delegation paperwork for Caregiver E. On 01/30/2024 at approximately 8:45 AM, Surveyor emailed Director A requesting the documentation again. Surveyor did not receive the documentation. On 01/31/2024 at approximately 11:00 AM, Surveyor interviewed Director A and Administrator/RN B. Director A stated Caregiver E found out that a new director had started and made a visit to the facility to talk with Director A. Caregiver E had told Director A that s/he was let go by former director. Director A reviewed Caregiver E's personnel file and didn't see any reason for termination or an investigation into any allegations of verbal abuse. Director A stated s/he didn't see any reason not to hire Caregiver E back at the facility. Director A indicated s/he sent all training documentation for Caregiver E to Surveyor. Director A acknowledged Caregiver E did not have documentation of emergency preparedness, needs and services of residents and change in condition training before working the floor. Administrator/RN B indicated s/he did provide delegation training to Caregiver E, however, did not sign the paperwork indicating s/he did the training. Administrator/RN B stated s/he would send the signed paperwork by the end of the day.	N 223		

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N 223	Continued From page 16 As of 02/01/2024, Surveyor did not receive the RN delegation paperwork.	N 223		
N 230	83.19 Orientation 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 2 of 2 of employees reviewed, obtained orientation training prior to performing any job duties. Director A and Caregiver I's records did not contain evidence for training in: job responsibilities; prevention and reporting of resident abuse, neglect and misappropriation of resident property; information regarding assessed needs and individual services for each resident; emergency and disaster plan and evacuation procedures; and recognizing and responding to resident changes of condition. This is a repeat deficiency, see Statement of	N 230		

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N 230	Continued From page 17 Deficiency (SOD) F8JP11, dated 01/21/2021. Findings include: On 03/19/2024 and 03/21/2024, Surveyor reviewed Director A and Caregiver I's employee records. Surveyor noted Director A was hired as the Director of the facility on 11/13/2023. Director A's record did not contain evidence of training in the following prior to assuming any job duties: job responsibilities; prevention and reporting of resident abuse, neglect and misappropriation of resident property; information regarding assessed needs and individual services for each resident; emergency and disaster plan and evacuation procedures; and recognizing and responding to resident changes of condition. On 03/21/2024, Surveyors interviewed Director A who stated s/he had not received training from the provider. Regional Director Y verified there was no evidence Director A completed or met an exemption for the listed training prior to assuming job duties. Surveyor noted Caregiver I was hired as a caregiver for the overnight shift on 12/18/2023. Caregiver I's record did not contain any evidence of any of the following training prior to assuming job duties: job responsibilities; prevention and reporting of resident abuse, neglect and misappropriation of resident property; information regarding assessed needs and individual services for each resident; emergency and disaster plan and evacuation procedures; and recognizing and responding to resident changes of condition. On 03/21/2024 at approximately 8:30 AM, Surveyors interviewed Regional Director Y who verified there was no evidence of training for Caregiver I.	N 230		

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N 230	Continued From page 18 Cross Reference N0169 DHS 83.12(5)(a) Notification Of Changes Affecting Resident N0386 DHS 83.35(3)(a) Comprehensive Individual Service Plan N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0348 DHS 83.32(3)(d) Rights of Residents: Free from Mistreatment N0525 DHS 83.47(2)(e) Other Evacuation Drills Y3244 Ch. 50.09(1)(L) Care	N 230		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and	N 243		

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N 243	Continued From page 19 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 2 of 2 of employee records reviewed, obtained all training as required within 90 days after starting employment. Director A and Caregiver I did not have training in resident rights, recognizing, preventing, managing and responding to challenging behaviors, and required client groups within 90 days after starting employment. Findings include: On 03/19/2024 and 03/21/2024, Surveyor reviewed Director A and Caregiver I's employee records. Surveyor noted Director A was hired on 11/13/2023 and his/her record did not contain	N 243		

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N 243	Continued From page 20 evidence of training or evidence of meeting an exemption for resident rights, recognizing, preventing, managing and responding to challenging behaviors, and required client groups. On 03/21/2024, at approximately 8:30 AM, Surveyors interviewed Director A and Regional Director Y. Director A stated s/he did not receive the required trainings. Regional Director Y verified the provider did not have evidence Director A completed or met an exemption for resident rights training, recognizing preventing, managing and responding to challenging behaviors, and required client groups training. Surveyor note: The department and provider's listed Administrator of the facility was Administrator RN B. Director A did not have Administrator qualifications and was not a certified nurse aide. Surveyor noted Caregiver I was hired 12/18/2023 and his/her record did not contain evidence of training or evidence of meeting an exemption for resident rights, recognizing, preventing, managing and responding to challenging behaviors, and required client groups trainings. On 03/21/2024, at approximately 8:30 AM, Surveyors interviewed Director A and Regional Director Y. Regional Director Y verified the provider did not have evidence Caregiver I completed or met an exemption for resident rights training, recognizing preventing, managing and responding to challenging behaviors, and required client groups training. Cross Reference N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment N0426 DHS 83.38(1)(b) Supervision N0433 DHS 83.38(1)(i) Behavior Management	N 243		

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N 247	Continued From page 21	N 247		
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 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.	N 247		

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N 247	Continued From page 22	N 247		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 2 of employee records reviewed, obtained all task specific training.

Director A, who had responsibilities for conducting resident assessments, service plan development, and providing assistance with activities of daily living, did not have training in assessment of residents, in individual service plan development, and in the provision of person care prior to assuming these duties. Director A who performed dietary duties, did not have training in dietary services within 90 days after assuming these job duties.

Caregiver I, who 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.

This is a repeat deficiency, see Statement of Deficiency (SOD) F8JP11, dated 01/21/2021.

Findings include:

On 03/19/2024 and 03/21/2024, Surveyor reviewed Director A and Caregiver I's employee records.
Surveyor note: The department and provider's listed Administrator of the facility was Administrator RN B. Director A did not have Administrator qualifications and was not a certified nurse aide.

Assessment

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N 247	Continued From page 23 Surveyor reviewed Director A's record and noted s/he was hired on 11/13/2023. Director A's record did not contain evidence of training or evidence of meeting an exemption for assessment training. On 03/21/2024, at approximately 8:30 AM, Surveyors interviewed Director A and Regional Director Y. Director A stated s/he completed resident assessments for the facility. Director A stated s/he had not received training from the provider. Regional Director Y verified there was no evidence Director A completed or met an exemption for assessment training prior to assuming these job duties. Individual Service Plan (ISP) Development The record for Director A, hired 11/13/2023, did not contain evidence of training or evidence of meeting an exemption for service plan development training. On 03/21/2024, at approximately 8:30 AM, Surveyors interviewed Director A and Regional Director Y. Director A stated s/he developed and updated individual service plans. Director A stated s/he had not received training from the provider. Regional Director Y verified there was no evidence Director A completed or met an exemption for service plan development training prior to assuming these job duties. Provision of Personal Care The record for Director A, hired 11/13/2023, did not contain evidence of training or evidence of meeting an exemption for personal care training. On 03/21/2024, at approximately 8:30 AM, Surveyors interviewed Director A and Regional Director Y. Director A stated s/he assisted with resident cares as needed when there were call-ins or schedule changes. Director A stated s/he had not received training from the provider in provision of personal cares. Regional Director Y	N 247		

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N 247	Continued From page 24 verified there was no evidence Director A completed or met an exemption for provision of personal cares training prior to assuming these job duties. Surveyor reviewed the record for Caregiver I and noted s/he was hired on 12/18/2023. His/her record did not contain evidence of training or evidence of meeting an exemption for personal care training. On 03/21/2024, at approximately 8:30 AM, Surveyors interviewed Director A and Regional Director Y. Director A verified Caregiver I provided personal cares to residents. Regional Director Y verified there was no evidence Caregiver I completed or met an exemption for provision of personal cares training prior to assuming these duties. Dietary The record for Director A, hired 11/13/2023, did not contain evidence of training or evidence of meeting an exemption for dietary training. On 03/21/2024, at approximately 8:30 AM, Surveyors interviewed Director A and Regional Director Y. Director A stated s/he completed assisted with dietary duties when needed. Director A stated s/he had not received training from the provider. Regional Director Y verified there was no evidence Director A completed or met an exemption for dietary training within 90 days after assuming these job duties. Cross Reference N0386 DHS 83.35(3)(a) Comprehensive Individual Service Plan N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0348 DHS 83.32(3)(d) Rights of Residents: Free from Mistreatment	N 247		

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N 247	Continued From page 25 Y3244 Ch. 50.09(1)(L) Care	N 247		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency.	N 310		

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N 310	Continued From page 26	N 310		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure an admission agreement was given in writing and explained orally to the prospective resident or legal representative for 1 of 1 (Resident 8) residents reviewed.

Resident 8 moved over from the sister facility across the street. Facility staff did not have Resident 8 or Resident 8's legal representative complete a new admission agreement.

Findings Include:

On 03/06/2024, the department received a complaint regarding resident to resident abuse allegations.

On 03/14/2024, Surveyor conducted an onsite visit to the facility. A sample of residents was selected, including the resident record of Resident 8.

Surveyor reviewed Resident 8's closed resident record. Resident 8 was admitted to a sister facility on 09/21/2020 with diagnoses to Alzheimer's Disease, early onset and hyperlipidemia. The record did not include a date of admission to this facility. Resident 8 has an activated HCPOA. Surveyor did not locate an admission agreement for Resident 8. Resident 8 was discharged from the facility on 03/08/2024.

On 03/14/2024 at 10:00 AM, Surveyor interviewed Caregiver M. Caregiver M verified Resident 8 moved over from sister facility across the street recently, but was unsure when.

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N 310	Continued From page 27 On 03/14/2024 at approximately 10:45 AM, Surveyor interviewed RN B. RN B indicated Resident 8 lived at sister facility across the street, but was unclear as to when Resident 8 moved over. RN B thought it was maybe a month or 2 months ago. RN B stated there was "no new admission agreement completed because not really new, just a transfer." On 03/18/2024, Surveyor requested again the completed admission agreements for Resident 8. On 03/19/2024, Surveyor received an email from Director A which stated "Admission Agreement - None located."	N 310		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 (Residents 3 and 4) residents reviewed were free from physical and sexual abuse. On 03/06/2024, Resident 8 was found in Resident 4's bed. Resident 8's pants were down, Resident	N 348		

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4's top was off and side of brief was torn. Resident 8 was attempting to perform a sexual act with Resident 4.

Additionally, on 03/06/2024, Resident 8 pushed Resident 3 to the floor in the common living room space.

Findings Include:

On 03/06/2024, the Department received a complaint indicating residents were abused by another resident at the facility.

On 03/07/2024, the Department received a facility self report regarding Resident 3, Resident 4 and Resident 8. The self report stated, "At approximately 2:30 AM March 6, [Caregiver I] was doing rounds when [s/he] heard screeming[sic] coming from the hallway. [S/he] went to check on residents. [S/he] went into [Resident 4's room] and [s/he] saw [Resident 8] on top of [Resident 4] in a missionary position. [Resident 8's] pants were down. [Resident 4] top was off and the side of the depends was torn. [Resident 8] was attempting to perform a sexual act. [Caregiver I] was able to intervene and separate the two. In the process [Resident 4] fell to the floor on [his/her] back. [Resident 8] bit and twisted [Caregiver I's] finger. [Caregiver I] was able to get [Resident 8] to [his/her] room where [s/he] layed[sic] down. [Caregiver I] went back into [Resident 4's] room where [s/he] assisted [Resident 4] up and into the bed and evaluated [him/her] at that time caretaker observed a red raised area on [Resident 4's] back. [Caregiver I] locked [Resident 4's] room to maintain [his/her] safety. [Caregiver I] notified ED[Executive Director] immediately. At approximately around 5AM, [Resident 8] woke up again and was in

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common area. As [Caregiver J] was going into med room, [s/he] heard a shuffle noise and turned around and found [Resident 3] on [his/her] bottom. [Resident 3] told [Caregiver J] "the [Resident 8] through[sic] me on the floor." [Resident 8] was standing in front of [Resident 3] on the floor and was pointing and laughing. [Resident 8] was escourted[sic] back to [his/her] room, and [Caregiver J] evualeted[sic] [Resident 3] for injuries. No visible signs of injury and [Resident 3] stated [s/he] was not hurt. ED notified again."

A facility policy titled, "Investigation, Notification, and reporting Requirements - WISCONSIN" with a revised date of 01/30/2024 stated, "Policy: The Administrator will provide prompt and complete reporting to ensure that all parties that need to know are informed of occurrences at the facility.
Procedure:
The Administrator or designee will report incidents as follows:
1. All reports will include, at a minimum:
a. The time, date, and place of the incident.
b. Individuals involved.
c. Details of the occurrence.
d. Actions taken to ensure residents' health, safety, and well-being...
3. Abuse, neglect, and misappropriation and injuries of an unknown source:...
c. Alleged abuse or neglect of a resident or misappropriation of property by a non-caregiver or resident. The alleged abuse must be reported to the OCQ on DHS Form F-62447, and to the county Elder-Adult-at-Risk agency as described under Section 46.90, Wisconsin Statutes. or the county Adult-at-Risk agency as described under Section 55.043, Wisconsin Statutes, whichever is applicable.

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4. Changes affecting a resident:...
b. Allegation of physical, sexual, or mental abuse or neglect of a resident. Immediately notify the resident's legal representative..."

On 03/14/2024, Surveyor conducted an onsite visit to the facility. Surveyor requested resident records for Residents 3, 4 and 8. From 03/14/2024 through 03/20/2024, Surveyor reviewed the resident records. The following was noted:

Resident 4
Resident 4 was admitted to the facility on 08/23/2023 with diagnoses to include Alzheimer's Disease, anxiety disorder and hypertension. Resident 4 has an activated HCPOA (Health Care Power of Attorney). Resident 4 is on hospice services. Resident 4's ISP (individualized service plan) indicated Resident 4 is able to ambulate and transfer independently, however, requires full assistance, including verbal and physical, with walking needs. Resident 4 requires 24-hour supervision.

On 03/06/2024 at 3:15 AM, a facility observation note for Resident 4 written by Director A stated, "Staff heard screaming from [Resident 4's] room. [Resident 8] was on top of [him/her] attempting to have sexual intercourse. [Resident 8] had [his/her] pants off and [Resident 4's] shirt off. [Resident 4] still had [his/her] brief on and [Resident 8] had [Resident 4's] legs up on [his/her] shoulders. Staff removed [Resident 8] from [Resident 4's] room."

On 03/06/2024 at 11:00 AM, a facility observation note for Resident 4 written by RN B states, "Assessed resident due to altercation with another resident. Resident has no bruising or any

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signs of abrasions noted."

A hospice note dated 03/06/2024 written by Hospice RN Z stated, "0408 on call received call from [Caregiver I] who states another resident was found on top of PT [patient] and now PT has a bruise on [his/her] back. Staff state PT is not in any pain and is currently sleeping. Advised of ETA [estimated time of arrival], [Caregiver I] states agreement with POC [plan of care]."

A hospice note dated 03/06/2024 at 7:41 AM written by Hospice RN Z stated, "Per staff PT was yelling out at around 0315 this morning and was found with another resident on top of [him/her]. On assessment PT alert to self...PT pushing writer away, writer unable to take PT vitals, skin check done, no visible injury, staff state PT has been weaker lately, advised staff to do frequent checks today, staff state understanding. Message left for [Family Member N], POA. Advised staff to call with any questions or concerns."

A hospice note dated 03/06/2024 at 9:41 AM written by Hospice RN-DCS(Director of Clinical Services) AA stated:
"0941: Call to facility x3 with no answer, left message with Director to return call to discuss incident that occurred this morning.
0953: Call to Directors cell phone with no answer, left message to return call.
0955: Call to Assistant Directors cell phone with no answer, left message to return call.
0956: Call to [Resident 4's][Family Member N]. [Family Member N] reports [s/he] did speak with on call nurse regarding incident but has not heard from facility in regards to what had occurred this morning. Writer advised, call was to follow up and make sure [s/he] was notified but to also inform we are looking into this situation and will keep

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[him/her] posted on any updates...
1123: Received call back from DON[Director of Nursing] at facility. States [s/he] is aware of the situation that occurred this morning, noting per staff, resident was found with another resident on top of her without clothes on. NO apparent injuries upon assessment. [S/he] has called and left a message with patient's POA to provide update. DON also stated [s/he] has not reported the incident as of yet but was working on it."

Resident 3
Surveyor reviewed Resident 3's resident record. Resident 3 was admitted to the facility on 05/13/2022 with diagnoses to include unspecified dementia, unspecified severity, with anxiety. Resident 3 has an activated HCPOA. Resident 3's most recent ISP dated 01/24/2024 does not indicate ambulation, transfer or mobility needs. The ISP does indicate Resident 3 requires 24-hour supervision and needs some assistance with self care but does not indicate what type of assistance.

On 02/11/2024 at 2:00 PM, a facility observation note for Resident 3 states, "Resident had been feeling a little nervous when [Resident 8] IS AROUND or INSIDE of room. Resident stated to writer [s/he] wants [his/her] door locked because [s/he] won't know when [s/he] enters."

On 02/16/2024 at 8:00 PM, a facility observation note for Resident 3 states, "Resident is very afraid of [Resident 8]. [S/he] is constantly trying to get in [his/her] room. [S/he] was found urinating in [his/her] sink yesterday."

On 03/06/2024 at 4:15 AM, a facility observation note for Resident 3 written by Director A and facility incident report stated, "As staff member

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walked through the common area [Resident 3] was sleeping on the couch outside the med room. Staff member did not see [Resident 8] walking down the hall. Staff member went into med room to get medication for a different resident and heard a shuffle noise by the couch. When staff approached the doorway [Resident 3] was found on the floor in front of the couch on [his/her] bottom. [S/he] told staff "the [woman/man] threw me on the floor." At this point [Resident 8] was standing in front of [Resident 3] pointing and laughing at [him/her]. Staff member redirected [Resident 8] back to their room as the other staff member assessed for injuries. Finding no sign of injury and [Resident 3] verifying [s/he] was not hurt, staff assisted [Resident 3] back up to the couch."

On 03/06/2024 at 11:00 AM, a facility observation note for Resident 3 written by RN B states, "Assessed resident for any signs of injury from incident with [Resident 8] this morning. Resident has no bruising or abrasions noted."

Resident 8
Surveyor reviewed Resident 8's closed resident record. Resident 8 was admitted to a sister facility on 09/21/2020 with diagnoses to Alzheimer's Disease, early onset and hyperlipidemia. Resident 8 recently moved to this facility from sister facility across the street, but staff can not provide a date when the move occurred. Resident 8 has an activated HCPOA. Resident 8's most recent ISP dated 03/18/2024 indicated Resident 8 is independent with ambulation and transferring. The ISP indicated Resident 8 has been identified as a wandering risk due to wandering into other resident's rooms but has no previous occurrences of elopement. Resident 8 was to be checked on every two hours at night to ensure

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safety. The ISP also stated that Resident 8 required redirection and documentation of all behaviors. Resident 8 was displaying combative behaviors with staff and residents, has been wandering in other resident rooms and has been urinating in inappropriate places. The ISP stated to have interventions in place that help alleviate behaviors but did not include what those interventions should be. Resident 8 was discharged from the facility on 03/08/2024.

On 01/26/2024 at 7:45PM, a facility observation note for Resident 8 stated, "The resident was following and staring at other [fe/male] residents and went inside their rooms."

On 02/09/2024 at 9:30PM, a facility observation note for Resident 8 stated, "Resident keeps going by [Resident 3] and going in [his/her] room when the door is unlocked. [Resident 3] seems to be scared to go in [his/her] room and go to bed now because [Resident 8] keeps going by [his/her] door and trying to get in [his/her] room when its locked."

On 03/04/2024 at 6:15AM, a facility observation note written by Director A stated, "While doing rounds staff member seen [Resident 8] in [Resident 4's] room where [s/he] was observed urinating on [Resident 4's] bed. Resident redirected [Resident 8] back to [his/her] bedroom with no further altercations."

On 03/06/2024 at 3:15AM, a facility observation note written by Director A stated, "Staff heard screaming from [Resident 4's room]. [Resident 8] was on top of [Resident 4] attempting to have sexual intercourse. [Resident 8] had [his/her] pants off and [Resident 4's] shirt off. [Resident 4] still had [his/her] brief on and [Resident 8] had

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[his/her] legs up on [his/her] shoulders. As staff member intervened to remove [Resident 8] from [Resident 4's] bed, [Resident 8] bit staff members hand and bend[sic] staff's finger back where it dislocated. Staff removed [Resident 8] from [Resident 4's] room and managed to get [him/her] back to [his/her] own room. Staff observed scratch marks on [Resident 8's] face from the victim fighting back.

Facility Investigation
Between 03/14/2024 and 03/21/2024, Surveyor requested and reviewed additional documentation related to the facility's investigation into the incidents between Resident 3, 4 and 8. The following was received:

"At 2:41am-I[Director A] received a call from [Caregiver I] (our 3rd shift worker) as [s/he] couldn't get ahold of [RCC L]. [S/he] stated that [s/he] was having an issue with a resident. I asked what was going on and [s/he] stated that [s/he] heard a scream come from down the hall. When staff went to go check on noise they noticed it was coming from [Resident 4's] room. (See incident report).

7:36am - Contacted [Resident 8's] POA and [family member] [Family Member O] at [phone number] and left message on voicemail for [him/her] to call me back regarding and [sic] incident.

7:38am - Called POA's cell phone at [phone number] and left same message

[emphasized in red ink] Update: 8:04am - [Resident 8's] POA [Family Member O] called back and I informed [him/her] of the two separate altercations that happened last night with two

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separate residents. POA not sure why these behaviors are occurring. I told [him/her] I would update [him/her] on any findings.

[emphasized in red ink] 11am - [Hospice Nurse P] from Compass[sic] stopped in and we discussed the incident

7:47am - Called [Resident 4's] POA [Family Member N] at [phone number] and left message on voicemail to give me a call back to discuss an incident that occurred.

7:50am Called and left message for [Caseworker Q] from Community Care regarding [Resident 8] and [Resident 4] (Community Care members)

7:51am - Called [Staffing agency worker R] from Stat agency - inquired if [s/he] had a staff member that [s/he] could supply for one-on-one care. [S/he] stated that [s/he] will see what [s/he] can figure out and will call me back asap.

7:55am - [Resident 3's] guardian [Family Member S] called and updated on the incident that occurred with [Resident 8] grabbing [him/her] and throwing [him/her] down to the floor. I informed that there wasn't any injury and that the nurse will also be doing a full body assessment.

[emphasized in red ink] 8:08am - Update: Residents POA called back and stated that [s/he] was going to be calling the police as [s/he] afraid for her mother's safety and doesn't want the male resident anywhere near [him/her]

[emphasized in red ink] 8:54am - Called Lakeland Care and left voice mail for [Lakeland Care Casemanager T] regarding [Resident 3] to call me back regarding incident (Updated care

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manager to [Lakeland Care Casemanager T] as we had [Lakeland Care Casemanager U] listed as case manager)

[emphasized in red ink] Roughly 10am - Police officer stopped in to follow up on incident with [Resident 3] due to [Family Member S] calling with concern for [Resident 3]. I explained to the officer of the investigation process I was completing, and [s/he] was completely satisfied with our process and was not concerned at all.

[emphasized in red ink] 11:13am - [Lakeland Care Casemanager T] from Community Care called back. I explained to [him/her] the incident that occurred and that we are following up. No injuries. I did let [him/her] know as well that the [family member] was unhappy and was going to be called [sic] the police.

[emphasized in red ink] 1:30pm - [RN B] contacted Bluestone regarding [Resident 8's] behaviors.

[emphasized in red ink] 3:57pm - I [Director A] called bluestone and left message for [Physician V] to call me back regarding their residents as I am trying to obtain UA[urinalysis] order or direction regarding [his/her] behaviors

[emphasized in red ink] 4:15pm Called Bluestone and left message for [Physician V] again and expressed importance of a return call back

Shortly after I arrived to work on 3/7/2024 approximately 8:30-8:45 am [Police Officer W] came to community. The reason for [his/her] visit was to observe and document the cognitive level of residents at the community. [S/he] stated that [s/he] would be contacting APS [Adult Protective

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Services] as [s/he] did not believe that [Resident 8] should be at this community and is at this time [sic] resident safety concerns.

Roughly around 11:45am resident was sent to hospital

[Director A]"

An email dated 03/07/2024 with a subject of "RDO (Regional Director of Operations) Statement" stated, "On 3.7.22 [sic] at approximately 10:45 I arrived at Linden and went to see residents [Resident 8], [Resident 4] and [Resident 3]. [Resident 3] was up and engaging with other residents and staff in common area, [s/he] appeared to be at baseline and was in good spirits. [Resident 4] was in bed and Hospice was there as well. [Resident 4] had an "episode" pulse rate up, blood pressure low, Hospice RN described as somewhat of vertigo and that [s/he] has had these in the past prior to incident that occurred on 3.6.24. Also saw [Resident 8] (in [his/her] room) and [s/he] was not wanting to see me, seemed mad. At this time, I made decision to move resident [Resident 4] to another community to ensure safety. We had put 1:1 on [Resident 8] since incident, but due to agency staff not being reliable, decision was made to move [Resident 4], Hospice was good with decision. At 11:13 I spoke with [Police Officer W] in regards to the incident on 3.6.24 involving [Residents 3, 4 and 8] at that time, I let [him/her] know the plan of moving [him/her], as [s/he] had given directive to staff earlier to keep [his/her] door locked and I let [him/her] know that while I understand the "why" it is against our regulation as it is a restraint and [s/he] may not be able to get out due to medical condition. [S/he] was good with plan and also let me know [s/he] contacted APS. When I spoke

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE CREEK PLACE III	5117 N CHERRYVALE AVENUE APPLETON, WI 54913

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with [him/her] briefly on 3.6.24 I had let [him/her] know we would be notifying state and APS as well. At approximately 11:45 We sent [Resident 8] out by ambulance for behaviors ([s/he] was angry, and we could not calm [him/her] down to get UA or vitals) to St. Elizabeth hospital. I called St. Elizabeth ER [Emergency Room] and gave community to ER hand off, letting them know of recent incident and police and APS involvement. I called [Police Officer W] back and let [him/her] know and [s/he] was going to work on getting a hold on [Resident 8] or placement. I called CCI[Community Care Inc.] and spoke with [Community Care worker X] to let [him/her] know of member in hospital and that [Police Officer W] was going to call [him/her]. Face sheet for [Resident 8] was sent to [Police Officer W] per [his/her] request. At this time, we have decided to hold on a move for [Resident 4] until we have further information on [Resident 8] and if [s/he] will return. We do not want to disrupt [his/her] surroundings until we have more information, we had left message for POA. I will continue to follow up with all parties involved as this is a continuing situation. They have my cell number. [signed by RDO Y]."

Police Reports
On 03/06/2024, Surveyor requested police reports from local area law enforcement agency. The following was noted:

A police report dated 03/06/2024 at 8:17 AM stated, "...I was dispatched to a battery complaint originating at [facility address provided]...I responded to Apple Creek and met with [Director A] who advised [s/he] knew why I had been contacted. [Director A] printed out a written statement completed by [Caregiver J] on 03/06/2024. The statement showed that the

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incident occurred on 03/06/2024 at 0420 hours. The statement from [Caregiver J] was as follows: "As staff member walked through the common area [Resident 3] was sleeping on the couch outside the med room. Staff member did not see [Resident 8] walking down the hall. Staff member went into med room to get medication for a different resident and heard a shuffle noise by the couch. When staff approached the doorway they found [Resident 3] on the floor in front of the couch on [his/her] bottom. [Resident 3] told staff "the [woman/man] threw me on the floor." At this point [Resident 8] was standing in front of [Resident 3] pointing and laughing at [him/her]. One staff member redirected [Resident 8] back to their room as the other staff member assessed for injuries. Finding no sign of injury and [Resident 3] verifying [s/he] was not hurt, staff assisted [Resident 3] back up to the couch."...I learned that both residents were on the memory care unit and were in advanced stages of Dementia/Alzheimer's Disease and would likely not be able to provide me with statements. Despite the fact that I was later notified of a sexual assault incident involving [Resident 8] and another resident (along with other incidents of violent or sexual behavior), I was originally told that his behavior alone was out of character for [Resident 8]. I found it unusual (and inappropriate) that [Director A] did not divulge the sexual assault incident to me during this contact...On 03/07/2024 at approximately 1204 hours, I responded to St. Elizabeth's Hospital and placed [Resident 8] on a Chapter 51.15 mental health hold due to [his/her] violent, sexual, and inappropriate behaviors over the previous week or so...Throughout the investigation of this specific incident, I did have reason to believe that [Resident 8] did push or throw [Resident 3] to the floor, but I did not establish probably cause that a

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battery occurred as there were no reported injuries to [Resident 3] and I was unable to interview [Resident 3] or [Resident 8] to gather more details or to establish true intent that [Resident 8] wanted to cause pain or harm to [Resident 3]."

A police report dated 03/06/2024 at 1329 hours stated, "...I responded- to [facility address provided] and I made contact with [Caregiver K]...I met with [Caregiver K] in a secluded area of the building for an interview. [His/her] initial reaction was that [s/he] was going to be fired from the business due to the fact [s/he] reported the incident with [Resident 8]. [Caregiver K] was not working in the building when the incident occurred and [s/he] worked day shift, so [s/he] did not witness the incident [him/herself]. [S/he] advised [s/he] spoke with staff, who mentioned they called [Director A] and [RCC (Resident Care Coordinator) L] overnight and they would not come in to address the situation. [Caregiver K] advised me [s/he] learned that [Caregiver I] was bitten by [Resident 8] and had [his/her] finger broken after [s/he] found [Resident 8] on top of [Resident 4] while [s/he] was in bed. [Resident 4] had been screaming for help and [s/he] was 'gouging' at [Resident 8] and trying to push [him/her] off of [him/her]. [Caregiver I] grabbed [Resident 8] to try to get [him/her] off of [Resident 4] and [s/he] noted [Resident 8] had an erection still. [Caregiver K] believed that [Resident 8] had penetrated [Resident 4]...It appeared that [s/he] doubted the management of Apple Creek Place would properly handle the incident...I was able to make telephone contact with [Caregiver I]. [Caregiver I] reported that on 03/06/2024 at approximately 0200 hours, [s/he] heard screaming down the hall in the Linden buildings and [s/he] responded to it. [S/he] found [Resident

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N 348	Continued From page 42 8] was on top of [Resident 4] in [his/her] room and [s/he] had [his/her] in a 'missionary position.' [Caregiver I] stated [Resident 8] had [his/her] clothes off and [his/her] genitalia was erect. [Caregiver I] stated that [Resident 4's] briefs were pulled from the side, but were still blocking [his/her] genitals. Based off of this, [Caregiver I] did not believe [Resident 8] penetrated [him/her]...[Caregiver I] stated [s/he] believed [Resident 8] was trying to penetrate [Resident 4], but only ended up 'dry-humping' [Resident 4]. I later confirmed this again with [Caregiver I]. [Caregiver I] stated [s/he] grabbed [Resident 8] and tried to pull [him/her] away from [Resident 4]. [Resident 8] got a hold of [his/her] finger and bit it, which drew blood. [Resident 8] also grabbed [Caregiver I's] finger and twisted it until [Caregiver I] heard a 'crack' noise. [Resident 8] had shoved [Resident 4] to the ground. [Caregiver I] reported there had been marks on [Resident 8's] back and face from the incident...[Caregiver I] stated [s/he] stayed at the facility after informing [Director A] of the incident because [s/he] did not want to leave other staff there alone. [S/he] then went to ThedaCare Urgent Care and it was determined [s/he] had a dislocated finger that required surgery to properly repair it...I referenced the incident where [Resident 8] pushed [Resident 3] to the ground and [s/he] believed that had occurred around 0500 hours. [S/he] knew [Caregiver J] had witnessed this and redirected [Resident 8] back to [his/her] room. [Resident 8] had reportedly come out and tried to push [Resident 3] again...I referenced the incident where [Resident 8] urinated on [Resident 4's] face. [S/he] stated [s/he] learned that [Resident 8] had [his/her] pants down and was trying to urinate on [Resident 4] and ended up urinating on [his/her] bed and [his/her] face. [Caregiver I] was not aware of any previous incidents with	N 348		

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[Resident 8]. [S/he] did mention that [Resident 8] typically went into women's rooms and where he was now, the women could not tell [him/her] "no." Prior to this (in the other buildings), [Resident 8] would get called out by other residents and it would be addressed. [Caregiver I] brought up the face that [Resident 8's] attacks were always at night and [s/he] did not believe [Resident 8] was safe to be around the residents because of [his/her] behavior. [Caregiver I] believed that [Resident 4] should be closely monitored until [Resident 8's] medications were changed or some other resolution happened...[Caregiver I] advised that if [s/he] did not hear [Resident 4] screaming, [s/he] would not have known anything was occurring. [Caregiver I] stated the door to [Resident 4's] room was locked last night because [Resident 8] tried to go back in by [him/her] after the sexual assault. [S/he] also mentioned previous issues where [Resident 8] had tried to sleep in [Resident 4's] room and [s/he] once saw [Resident 8] lifting the blanket off of [Resident 4]. [Caregiver I] believed [Resident 8] was possibly trying to look under [his/her] skirt, but [s/he] was not certain..."

Interviews
Surveyors attempted to contact Caregiver I and Caregiver K multiple times, but they did not return correspondence.

On 03/14/2024 at 10:00 AM, Surveyor interviewed Caregiver M. Caregiver M stated s/he was not working during the incident but came in for the day shift on 03/06/2024 which starts at 6am. Caregiver M indicated Caregiver I had told [him/her] that Caregiver I heard Resident 4 screaming for help so Caregiver I went to Resident 4's room. Caregiver I found Resident 8 on top of Resident 4. Resident 4's shift was off.

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N 348	Continued From page 44 Caregiver I was unsure if Resident 4's brief was off, maybe it was ripped, but Resident 8 was "in motion" of a sexual act. Caregiver M reported that Caregiver I said [s/he] went to intervene and Resident 8 bit [him/her] and broke [his/her] finger. When Caregiver M arrived Resident 3, 4 and 8 were in their rooms. Caregiver M asked Caregiver I if s/he called management. Caregiver I told Caregiver M that s/he did call Director A and spoke with him/her. Caregiver M also instructed Caregiver I to make an observation note of the incident. Caregiver M indicated Resident 8 stayed in room all day. Resident 4 didn't come out of room, so Caregiver M went to check on him/her. Caregiver M stated Resident 4 was found in room sitting in chair, s/he started crying and saying, "I can't do this anymore...I don't know what happened but I can't do this anymore." Caregiver M got some magazines for Resident 4 to help calm him/her down. Caregiver M stated Resident 4 wasn't really eating and didn't come out of his/her room for a few days after the incident. On 03/14/2024 at approximately 10:30 AM, Surveyor interviewed RN B. RN B stated s/he was notified around 8/8:30am of the incidents with Resident 3, 4 and 8. RN B stated s/he found out from Caregiver M. Caregiver M had reported that Resident 8 was found in Resident 4's room and then came out and pushed Resident 3. RN B stated s/he was very surprised to hear this information. RN B stated s/he assessed Resident 3, 4 and 8 and none of them had any injuries. RN B stated caregivers had indicated Resident 8 had scratches on his/her face but RN B stated it was Resident 8's eczema. RN B stated Resident 4's hospice agency was notified, along with the family members of all 3 residents. RN B stated police were notified by Resident 3's family member who called them. RN B stated "We did call police	N 348		

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N 348	Continued From page 45 same time as [Resident 3's family member]. RN B stated "we told them [police] about the incident with [Resident 8] and [Resident 4]." RN B verified no one from the facility contacted Adult Protective Services or the police to report the incidents. RN B stated no one saw Resident 8 push Resident 3 off the couch. Resident 8 was just seen pointing and laughing, no one saw Resident 8 do anything. RN B stated based on this "really not sure what happened." RN B had indicated staff were instructed to do more frequent checks on Resident 3 and 4. RN B stated s/he provided the 1:1 to Resident 8. Surveyors requested the full investigations into the incidents with Resident 3, 4 and 8. On 03/18/2024 at 10:50 AM, Surveyor interviewed Family Member S. Family Member S verified s/he is the guardian for Resident 3. Family Member S indicated s/he did receive a phone call from the facility but could not remember the name of the person who called him/her. Family Member S stated it was the "head nurse of the facility, s/he runs it." Family Member S stated it was after 8:00 AM when s/he received the call. Family Member S was told Resident 3 was walking in the hallway and another resident grabbed Resident 3 and "threw" Resident 3 to the floor. Family Member S stated s/he was told this happened around 5:15/5:30 AM. Family Member S stated s/he was concerned for Resident 3's safety and therefore called the police to check on Resident 3. Family Member S stated the officer said s/he would go and check on Resident 3. Family Member S indicated the officer was very informative and told Family Member S that after the visit the other resident was removed from the facility. Family Member S stated, "made me happy that [s/he] was gone."	N 348		

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N 348	Continued From page 46 On 03/18/2024 at 7:00 PM, Surveyor interviewed Family Member N. Family Member N verified s/he was the HCPOA for Resident 4. Family Member N stated s/he was notified about the incident with Resident 8 by the hospice agency in the morning on the day of the incident. Family Member N could not remember if the facility had called to discuss the incident with him/her but definitely heard from hospice agency and then the police department called and spoke with Family Member N as well. Family Member N stated initially s/he was told that Resident 4 was in his/her room and another resident attempted to sexually assault him/her. Then Family Member N found later later that Resident 4 was found unclothed in room and the other resident was found on top of Resident 3. Family Member N was aware that Resident 8 had moved out of the facility. Family Member N indicated s/he did make a visit to see Resident 4 after the incident. Family Member N stated Resident 4 was hardly communicating and has been laying in bed more often and pulse has been up but Family Member N suspects Resident 4's dementia is getting worse. Family Member N stated s/he was upset because s/he was informed by either police officer or hospice [Family Member N could not remember] that the other resident was found in Resident 4's room a few nights earlier urinating on Resident 4 while in his/her bed. Family Member N stated s/he was never made aware of this and it "bothered me terribly they didn't call me about urination incident...that's a red flag." On 03/21/2024 at approximately 9:00 AM, Surveyor conducted an exit meeting with Director A, RN B, RDO Y, VP (Vice President) of Clinical Operations BB and Director of Compliance CC. Surveyor discussed the investigation timeline compared to hospice, police reports and	N 348		

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N 348	Continued From page 47 interviews. RDO Y acknowledged the facility staff did not contact police or legal responsible parties immediately after incidents. Additionally, RDO Y acknowledged the facility did provide 1:1 for Resident 8 while s/he was in the facility, this 1:1 was not provided until several hours after the incident. RDO Y also verified the facility had not taken any steps to mitigate the risk of this occurring in the future. In summary, on 03/06/2024 around 2:30 AM Resident 8 was found in Resident 4's bed. Resident 8's pants were down, Resident 4's top was off and side of brief was torn. Resident 8 was attempting to perform a sexual act with Resident 4. Later on 03/06/2024 at approximately 5:15 AM, Resident 8 pushed Resident 3 to the floor in the common living room space. The facility did not provide an environment free from abuse or mistreatment for Residents 3 and 4. Cross Reference: N0433 DHS 83.38(1)(i) Behavior Management	N 348		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the 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	N 386		

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N 386	Continued From page 48 responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not develop a comprehensive individual service plan (ISP) for Resident 1 and Resident 5. Resident 1's most recent ISP dated 01/24/2024 did not contain information related to Resident 1's mobility and transferring needs, dietary needs, medication management including diabetic management, behavior patterns, social participation needs, toileting needs and fall interventions. Resident 5's most recent ISP with print date 01/24/2024 and noted it did not contain information related to Resident 5's mobility and transferring needs, dressing needs, toileting needs, dietary needs, eating needs, medication management and administration needs, mental health needs, social participation needs, transporation needs, appointment coordination needs, and choking/swallowing needs. This is a repeat deficiency, see Statement of Deficiency (SOD) F8JP11, dated 01/21/2021. Findings Include: On 01/24/2024, Surveyors conducted an onsite visit to the facility. On 01/02/2024 and 01/03/2024, the department received complaint information alleging ISPs were not comprehensive.	N 386		

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RESIDENT 1
Resident 1 was admitted to the facility on 10/30/2023 with diagnoses to include type 2 diabetes mellitus, depression, anxiety and dementia.

A facility document titled, "Annual Assessment" dated 11/22/2023 indicates Resident 1 requires full assistance with bathing and dressing and as needed assistance with oral cares. The assessment does not contain information related to eating, toileting, mobility and transferring, medication administration, behavior patterns, physical health, mental health, and social participation.

Surveyor reviewed an incident report dated 11/23/2023. The report stated, "Writer came into resident's room finding resident on the floor right behind door. Writer called for help immediately and asked resident what happened. Resident stated, "I don't know." Writer did ask if [s/he] remembers hitting [his/her] head or anything else, [s/he] did confirm hitting [his/her] head and by how [s/he] was laying hit [his/her] back from the pain [s/he] was experiencing. Over a few minutes resident began to get verbally hostile saying, "Your going to hell for doing this." And repeated it as writer reassured that everything will be okay and that writer was there to help [him/her] and make sure [s/he] is safe while an ambulance was on the way."

Resident 1's most recent ISP dated 01/24/2024 did not contain information related to Resident 1's mobility and transferring needs, dietary needs, medication management including diabetic management, behavior patterns, physical and mental health, social participation needs, toileting needs and fall interventions.

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N 386	Continued From page 50 RESIDENT 5 On 01/30/2024, Surveyor reviewed Resident 5's record and noted s/he was admitted to the facilty on 08/16/2023. Surveyor noted Resident 5's record did not include diagnoses. Surveyor reviewed a typed note from the kitchen listing Resident 5's allergies and diet restrictions: "[Resident 5] Allergies: Seafoods Cannot have due to meds Broccoli Grapefruit Grapefruit juice Cranberries Cranberry juice" On 01/31/2024 at approximately 7:45 AM, Surveyor interviewed Guardian G who reported per Resident 5's medical history, his/her diagnoses were neurocognitive disorder, congestive heart failure, heart disease, hypertension, dysphagia, kidney disease, anemia, depression, and gout. Guardian G stated s/he had requested Resident 5 to be assessed and his/her care plan to be updated to reflect his/her diagnoses and care needs numerous times from December 2023-current. Guardian G reported Resident 5 utilized a walker for mobility, had diet restrictions and allergies, was incontinent, but independent with toileting, staff administered medications, staff needed to assist with his/her appointments and transportation, s/he dressed his/her self, but needed reminders at times, ate in his/her room, and had dysphagia. Guardian G also stated s/he was concerned that staff did not have documentation to address Resident 5's diagnoses of depression and his/her current state of self isolation due to not feeling safe to leave	N 386		

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N 386	Continued From page 51 his/her room. On 01/31/2024, Surveyor reviewed Resident 5's most recent ISP with print date 01/24/2024 and noted it did not contain information related to Resident 5's mobility and transferring needs, dressing needs, toileting needs, dietary needs, eating needs, medication management and administration needs, mental health needs, social participation needs, transportation needs, appointment coordination needs, and choking/swallowing needs. On 01/24/2024 at approximately 2:38 PM, Surveyors interviewed Director A who stated ECP (electronic member record) was a new program to them. S/he indicated staff will be getting training in ECP on 01/25/2024 because many records need to be updated. Director A stated many things need to be assigned tasks, so that staff are following care plans and care plans need to be updated to reflect resident needs. Director A stated "we really need to update and individualize the care plans." On 01/31/2024 at approximately 11:00 AM, Surveyors interviewed Director A and Administrator RN B who verified resident care plans needed to be comprehensive. Cross Reference: N0426 DHS 83.38(1)(b) Supervision	N 386		
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.	N 388		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not implement and follow the ISP (Individual Service Plan) for 1 of 1 (Resident 2) residents reviewed.

Resident 2's most recent ISP dated 01/24/2024 indicated Resident 2 is to be weighed every month. Resident 2's record did not contain monthly weights.

Findings Include:

On 01/10/2024, the department received a complaint regarding resident weight loss.

On 01/24/2024, Surveyors conducted an onsite visit to the facility. A sample of residents was selected, including Resident 2.

Resident 2 was admitted to the facility on 08/29/2023 with diagnoses to include type 2 diabetes mellitus, hyperlipidemia, anxiety, and Alzheimer's disease.

Resident 2's most recent ISP dated 01/24/2024 indicated Resident 2 is to be weighed every month.

Surveyor requested Resident 2's weights since admission. Surveyor was provided the following weights:
-11/06/2023 135.8 lbs (pounds)
-11/23/2023 136 lbs
-11/26/2023 132.9 lbs

On 01/30/2024 at 8:45AM, Surveyor interviewed Family Member F. Family Member F verified s/he was Resident 2's HCPOA (health care power of attorney). Family Member F stated Resident 2

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N 388	Continued From page 53 moved to the facility in August 2023 and the transition has been tough on Resident 2. Family Member F stated s/he started to notice Resident 2 losing weight and requested Resident 2 be weighed in November. Family Member F stated it was odd that they weren't checking weights regularly and felt the only time the facility checked Resident 2's weight was when Family Member F asked. Family Member F thought Resident 2 had lost 25-30 lbs since admission. Family Member F indicated the facility was offering meals and snacks and Resident 2 drinks a Boost every day. Family Member F stated Resident 2's physician was aware of the weight loss and sees Resident 2 monthly. A physician visit summary dated 11/30/2023 stated, "[Resident 2] had a weight loss and has been feeling sick to [his/her] stomach recently..." Additionally, the summary states, "monitor weight, dietary intake, upset stomach..." A physician visit summary dated 12/12/2023 stated, "Continue current plan of care. Monitor weights, appetite..." A physician visit summary dated 01/25/2024 stated, "Monitor for loose stools and weight loss." On 01/31/2024 at approximately 11:00AM, Surveyor interviewed Director A. Director A verified the only weights the facility had were from November. Director A indicated the facility needed to do a better job with following the care plan and taking weights.	N 388		
{N 426}	83.38(1)(b) Supervision.	{N 426}		

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{N 426}	Continued From page 54 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, record review, and interview, the provider did not provide supervision to Resident 2, Resident 4, Resident 5, and Resident 6 to meet their needs. Resident 2 and Resident 4 were identified as having exit seeking, verbal and physical aggression, and wandering behaviors, including wandering into other residents' rooms. Resident 5 and Resident 6 experienced other residents entering their rooms on multiple occassions. Resident 5 and Resident 6 had significant concern and fear for their safety and staff not providing supervision to meet their needs. This requirement is being cited for a third time. See Statements of Deficiency (SOD) P4Z911 dated 01/17/2022 and SOD P4Z912 dated 09/26/2023. Findings include: The provider is licensed to serve up to 22 residents who may be physically disabled, of advanced age, terminally ill, and/or have Alzheimer's/dementia.	{N 426}		

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{N 426}	Continued From page 55 On 10/26/2023, the department received complaint information alleging residents were exit seeking and not properly supervised. On 01/02/2024 and 01/03/2024, the department received complaint information alleging residents had behaviors that made other residents feel unsafe in their rooms and facility. On 01/24/2024 at approximately 1:48 PM, Surveyors interviewed Caregiver D who stated some residents have call light pendants and some don't. S/he said call lights that are on go to a phone that caregivers are supposed to carry and are also listed on the computer located in the office off the common area. Caregiver D stated it was standard practice and expectation that "we should be getting to residents [call lights] within 7 minutes, but that doesn't happen." Surveyor inquired about how staff document behaviors. Caregiver D stated, "We are supposed to chart at the end of the shift what behavior and how it was handled in ECP [electronic member record], but it is rarely done." Caregiver D stated, "I feel like if we had activities, we would have less behaviors." On 01/24/2024 at approximately 2:38 PM, Surveyors interviewed Director A who stated staff were in need of training in ECP and observation notes and behavior monitoring were a work in progress. RESIDENT 2 On 01/30/2024, Surveyor reviewed Resident 2's record and noted s/he moved into the facility on 08/29/2023 with diagnoses of Alzheimer's disease, diabetes, and anxiety disorder.	{N 426}		

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{N 426}	Continued From page 56 Surveyor reviewed Resident 2's most recent individual service plan (ISP) with print date 01/24/2024 and noted s/he had an activated Power of Attorney of Healthcare, required 24/7 supervision, and required some assistance to make his/her needs known. Surveyor noted "DESTRUCTIVE/ABUSIVE - SUPERVISION ... Directions: Must be supervised to help prevent and alleviate any destructive/abusive behaviors or incidents. Contact proper providers if necessary. Schedule: Daily As Needed. Resident's Needs/Prefences: has history of bad anxiety and will throw things and become destructive. Resident's Desired Goals & Outcomes: To have complete assistance from staff with all incidents/episodes of destructive/abusive behavior. And to try and maintain a low level of these behaviors ... ATTITUDE - SUPERVISE/INTERVENE [Mental Health/Attitude] Directions: Redirect negative attitudes. Notify appropriate provider (psychiatrist, doctor) when necessary. Schedule: Daily As Needed. Resident's Needs/Preferences: history of bad anxiety resident at times have a negative attitude. Resident's Desired Goals & Outcomes: To avoid negative attitudes and redirection from staff. Music can be a good distraction ...BEHAVIOR MONITORING [Mental Health/Attitude] Directions: Provide supervision and assistance in preventing and redirecting suicidal thoughts and behaviors. Report and document incident for proper provider ... AGGRESSIVE/COMBATIVE - FULL INTERVENTION ...Directions: Constantly supervise and assist in redirecting aggressive/combative behaviors. Notify appropriate providers if necessary ...Resident's Needs/Preferences: resident at times can get very anxious making [him/her] agitated and	{N 426}		

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combative. Resident's Desired Goals & Outcomes: To receive complete assistance from staff preventing/alleviating aggressive and/or combative behaviors."

On 01/24/2024 at approximately 8:45 AM, Surveyor interviewed Caregiver C who said Resident 2 was a frequent exit seeker. S/he said Resident 2 would become very upset after family visits and would then ask and try to leave multiple times. Caregiver C described Resident 2 as being pleasantly confused at baseline, but escalated quickly when agitated. Caregiver C indicated Resident 2 had difficulty finding his/her room and would frequently go into other resident's rooms and bathrooms.

On 01/24/2024 at approximately 1:48 PM, Surveyor interviewed Caregiver D who stated Resident 2 was exit seeking a lot after his/her family was there. Caregiver D indicated s/he has had to redirect Resident 2 out of other resident's rooms as s/he was confused as to where his/her room was.

RESIDENT 4
On 01/30/2024, Surveyor reviewed Resident 4's record and noted s/he was admitted to the facility on 08/28/2023 with diagnoses of Alzheimer's disease, anxiety disorder, atherosclerotic heart disease, and low back pain.

Surveyor reviewed Resident 4's most recent ISP with print date 01/24/2024 and noted Resident 4 had an activated Health Care Power of Attorney, was identified as a Wander Risk, was on hospice, required 24-hour supervision, and needed assistance to make his/her needs known. "PSYCHOTROPIC MEDICATIONS - USING ... Using psychotropic medications related to

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specific behaviors: See MAR [medication administration record] for medications ...
WANDERING/ELOPEMENT - SUPERVISION [Behavior Patterns/Wandering Risk] Directions: Provide supervision and redirection to avoid and prevent wandering episodes. If wandering occurs, determine follow-up plan. Schedule: Daily.. as needed. Resident's Needs/Preferences: To receive full supervision and redirection from staff to avoid and prevent wandering episodes. Resident's Desired Goals & Outcomes: To maintain low level of wandering episodes ...
BEHAVIOR MONITORING [Mental Health/Attitude] Directions: Provide supervision and assistance in preventing and redirecting suicidal thoughts and behaviors. Report and document incidents for proper provider. Schedule: Daily @ 5:45 AM, 1:45 PM, 9:45 PM, As Needed. Resident's Needs/Preferences: Receiving supervision and assistance in all areas of preventing and redirecting suicidal thoughts and behaviors. Resident's Desired Goals & Outcomes: To receive assistance from staff and from proper provider (i.e. psychiatrist) when necessary...
INTERACTION - ASSIST [Mental Health/Interaction] Directions: Assist redirecting negative interactions with others. Supervise and assist. Notify appropriate provider (psychiatrist, etc.) when necessary. Schedule: Daily As Needed. Resident's Desired Goals & Outcomes: To avoid any negative interactions with others. Service Provider Responsibilities: Staff will give all ordered medications. Staff will update RCC/RN [Resident Care Coordinator/Registered Nurse] if any changes occur ...
AGGRESSIVE/COMBATIVE - FULL INTERVENTION [Mental Health/Aggressive/Combative] Directions:

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Constantly supervise and assist resident in redirecting aggressive/combative behaviors. Notify appropriate providers if necessary. Schedule: Daily As Needed. Resident's Needs/Preferences: To receive complete assistance and aiding in alleviating aggressive/combative situations. Resident's Desired Goals & Outcomes: To receive complete assistance from staff preventing/alleviating aggressive and/or combative behaviors. Service Provider Responsibilities: Staff will monitor resident for any sign of aggression and redirect resident as needed. Measurable Goals, Outcomes and Review: Residents aggression will be controlled as much as possible."

Surveyor reviewed Resident 4's observation notes and noted:
12/18/2023 5:45 PM - " ...Hospice stated resident was extremely aggressive and could not do shower. Resident continuously refusing care from staff."
01/10/2024 4:30 AM - "Staff found resident going through other residents rooms at 0430 [AM], [s/he] started to get upset when staff redirected [him/her] out, and angrily went to [his/her] room."

Surveyor reviewed Resident 4's Care History and noted:
01/19/2024 9:29 PM - "What thoughts or behaviors were exhibited? Walking around with no brief on."
01/21/2024 08:24 PM - "What thoughts or behaviors were exhibited? Refused cares."

RESIDENT 5
On 01/30/2024, Surveyor reviewed Resident 5's record and noted s/he was admitted ot the facility on 08/16/2023. According to Guardian G, Resident 5 had a medical history of

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neurocognitive disorder, congestive heart failure, heart disease, dysphagia, chronic kidney disease, depression, and hypertension.

Surveyor reviewed Resident 5's most recent ISP with print date 01/24/2024. Surveyor noted Resident 5 had a legal guardian, required 24-hour supervision, and was able to make his/her needs known.

Incident involving Resident 4 and Resident 5:
On 01/24/2024, Surveyor reviewed self-report information submitted by provider regarding an incident that occurred between Resident 4 and Resident 5 on 09/29/2023 at approximately 10:30 PM. Resident 4 was found by Resident 5 using Resident 5's bathroom in his/her room. Resident 5 told Resident 4 s/he needed to leave. Resident 4 hit Resident 6 in the face and squeezed his/her forearm. Resident 5 called for help and staff responded. Staff redirected Resident 4 out of Resident 5's bathroom and room. Resident 5 was extremely upset and did have redness on his/her forearm and above his/her left eye. Resident 5 had requested to keep his/her door shut and locked. Staff reached out to Resident 4's physician and hospice to seek additional PRN's for agitation. Surveyor note: Resident 4 and Resident 5's rooms were next to one anothers.

On 01/24/2024 at approximately 9:05 AM, Surveyors interviewed Director A. Director A stated Resident 5 had a lock on his/her door following the incident in September. S/he indicated a couple of weeks ago, Guardian G voiced Resident 5 felt like a prisoner because s/he had a locked door, so Resident 5 was moved to a room on the other side of the building, in a different hall than Resident 4. Director A

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indicated s/he thought Resident 5 was happy with the move, but was told s/he doesn't feel safe and was moving from the facility.

On 01/24/2024 at approximately 10:50 AM, Surveyor interviewed Resident 5 who stated "no, I still do not feel safe here." Resident 5 stated another resident "who knows how to open doors" had come in 3 times in the past few days. Resident 5 stated one of the times, s/he was in the bathroom on the toilet and the resident came in. Resident 5 said s/he had to get off of the toilet to get the resident to get out. S/he said s/he requests staff to keep his/her door locked on the outside because s/he doesn't feel safe. Resident 5 said s/he was glad to be moving and hopefully would live somewhere s/he felt the residents were more supervised. Surveyor inquired whether s/he had pressed his/her call light when the other residents have come into his/her room and Resident 5 said yes. Surveyor asked if staff come timely to his/her call light and Resident 5 stated no. S/he recalled having to wait up to 45 minutes and so s/he didn't want to depend on the call light when other residents come in.

On 01/31/2024 at approximately 7:45 AM, Surveyor interviewed Guardian G who took over Resident 5's guardianship in December 2023. Guardian G reported Resident 5 had said on multiple occasions that s/he feels like a prisoner at the facility, that s/he felt unsafe with the other residents who lived there, that the staff were not available when s/he needed them, and s/he did not feel safe leaving his/her room. Guardian G indicated Resident 5 never leaves his/her room now unless s/he is going out with his/her friend. S/he will not attend meals and will not go into the common areas independently because s/he is scared. Guardian G shared a copy of an email to

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Director A reporting Resident 5's concerns of feeling unsafe. Guardian G stated s/he was by Director A that Resident 4 had physically aggressed towards other residents in the past in addition to Resident 5 and there was nothing s/he could do. Guardian G inquired about the safety plan for Resident 5 since s/he felt unsafe and Guardian G said moving rooms was the only intervention provided. Surveyor inquired whether Resident 5 felt safe in his/her new room and Guardian G stated no. Guardian G shared Resident 5 had reported Resident 2 had gone into his/her room multiple times because s/he thought it was his/her room. Guardian G said when s/he had addressed concern of Resident 2 going into Resident 5's room, staff have said to him/her that "it's just the way [Resident 2] is." Guardian G said Resident 5 now keeps his/her room locked again and was voicing feeling unsafe. Guardian G indicated s/he was moving Resident 5 to a new facility.
On 01/24/2024 at approximately 10:47 AM, Surveyor interviewed Caregiver C who reported Resident 5 used to be in a room next to Resident 4, but had recently been moved to the other hall. Caregiver C indicated Resident 4 still requested his/her door to be locked as s/he voiced fear of other residents.
On 01/24/2024 at approximately 1:48 PM, Surveyor interviewed Caregiver D who stated s/he had not heard that another resident had gone into Resident 5's room, but did not doubt it. Surveyor inquired who it could have been and Caregiver D stated it was likely Resident 2 or Resident 7. Caregiver D stated "if we had time to keep residents busy and time to watch them, they wouldn't be going into other people's rooms."

RESIDENT 6
On 01/30/2024, Surveyor reviewed Resident 6's

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record and noted s/he was admitted to the facility on 09/27/2023 with diagnoses of schizoaffective disorder, bipolar disorder, major depressive disorder, social phobia, anxiety disorder, dementia, paranoid personality disorder, Parkinson's disease, insomnia, Crohn's disease, osteoporosis, and personal history of suicidal behavior.
Surveyor reviewed Resident 6's most recent ISP with print date 01/24/2024. Surveyor noted Resident 6 was able to communicate fully and make his/her needs known. Resident 6 required assistance with all personal cares.

On 01/24/2024 at approximately 10:00 AM, Surveyor interviewed Resident 6. Resident 6 voiced concern about long call light wait times, indicating s/he had waited up to an hour at times. Resident 6 shared s/he liked it at the facility, but s/he did not always feel safe. Resident 6 stated another resident comes into his/her room frequently and s/he does not like it. Resident 6 stated s/he did not know who the resident was, but that it had happened more than once and that s/he goes through his/her closet and steals his/her clothes. Resident 6 recalled a time where the resident came into the room and s/he had yelled at him/her to leave and s/he wouldn't leave right away. Surveyor observed Resident 6 was confined to his/her wheelchair. Resident 6 voiced fear of him/her coming back in every day. Surveyor asked if s/he had pressed his/her call light for assistance when the resident comes in his/her room and Resident 6 stated s/he had and s/he was afraid staff would not come in time before something bad would happen.

At approximately 10:16 AM, Surveyor pressed Resident 6's call light to test it and observed it to be blinking green. At approximately 10:32 AM,

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{N 426}	Continued From page 64 Surveyor went to the computer located in the office located off the common area where call lights alarms were listed and verified Resident 6's call light was on the screen as actively on. Surveyor located Caregiver C standing in the dining room and inquired if s/he had seen Resident 6's call light. Caregiver C did not have the phone that the call lights were sent to. Surveyor observed Caregiver C go to the office and grab that phone and verify Resident 6's call light was on. Surveyor notified Caregiver C s/he was testing the call light. Caregiver C stated they were supposed to be carrying the phone. Surveyor inquired whether s/he knew of another resident going into Resident 6's room and Caregiver C stated yes. S/he said s/he had heard that Resident 4 had gone into Resident 6's room and stole his/her clothes. Caregiver C said Resident 6 requested his/her door to be locked on the outside at all times now to prevent other residents from coming in. Caregiver C said Resident 6 had voiced fear of other residents to him/her. On 01/31/2024 at approximately 11:00 AM, Surveyors interviewed Director A and Administrator RN B who verified concerns with Resident 2, and Resident 4's behaviors. Director A and Administrator RN B verified awareness of Resident 5 and Resident 6 voicing feeling unsafe. Surveyor referenced Caregiver D stating that s/he felt residents would have less behaviors and go into other resident rooms less if they had time to supervise residents and provide activities. Director A stated "I absolutely agree with you." Director A and Administrator RN B acknowledged awareness of long call light wait times. Surveyor requested a copy of the call light log on 01/24/2024 at 9:00 AM, 3:30 PM, 01/25/2024 at 12:56 PM, and 01/31/2024 at 11:00 AM. Director	{N 426}		

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{N 426}	Continued From page 65 A stated s/he would sent it to Surveyors. As of 02/02/2024, Surveyors had not received the call light log. In conclusion, Resident 2, and Resident 4 were identified to have exit seeking behaviors, were verbally and physically aggressive towards others, and had known instances of entering other resident rooms. Resident 5 and Resident 6 voiced fear of living in the facility and felt that they needed to keep their doors locked to keep other residents from entering their rooms. Resident 5 and Resident 6 do not feel safe leaving their rooms. Resident 5 is moving to a new facility. Cross Reference: N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan N0427 DHS 83.38(1)(c) Leisure Time Activities N0433 DHS 83.38(1)(i) Behavior Management N0499 DHS 83.45(3) Toxic Substances N0654 DHS 83.59 (4)(f) Delayed Egress Department Approval	{N 426}		
{N 427}	83.38(1)(c) Leisure time activities. 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: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in	{N 427}		

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the activity program. The CBRF shall develop and post the activity schedule in an area available to residents.

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not provide a daily activity program to meet the interests and capabilities of the residents. While present at the facility from approximately 8:30 AM to 1:00 PM and 1:45 PM to 4:00 PM, Surveyors did not observe residents engaged in activities and staff providing activities.

This is a repeat deficiency. See Statement of Deficiency (SOD) P4Z912, dated 09/26/2023.

Findings Include:
The provider is licensed to serve up to 22 residents who may be physically disabled, of advanced age, terminally ill, and/or have Alzheimer's/dementia.

On 01/10/2024, the department received complaint information alleging there were no activities or life enrichment at the facility.

On 01/24/2024, Surveyors conducted a verification visit at the facility. While present at the facility from approximately 8:30 AM to 1:00 PM and 1:45 PM to 4:00 PM, Surveyors observed residents to be sitting in the common areas, wandering the facility, and sitting in their rooms.

On 01/24/2024 at approximately 8:30 AM, Surveyors observed the activity calendar for January 2024 hanging on the wall. Surveyor noted the following activities were scheduled for

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{N 427}	Continued From page 67 01/24/2024: -9:00am Morning News & Coffee -10:30am Sit & Be Fit -1:00pm EZ Random Trivia -2:15pm Hand Massages -6:30pm Wheel of Fortune Club -7:00 Bucks vs. Cavaliers On 01/24/2024 at approximately 2:00 PM, Surveyors interviewed Caregiver D. Caregiver D indicated the facility was a memory care unit. Caregiver D verified no activities were completed with residents today. S/he stated "we don't do any activities on the calendar; I think that [the activity calendar] is a lot for show." Caregiver D stated they do not have the supplies to conduct the activities and not enough staff to perform the activities. Caregiver D indicated s/he had given a list of supplies to the marketing manager to pick up and then staff could do activities. Caregiver D stated that was probably about a month ago and s/he hadn't heard anything, nor did s/he receive the supplies. Caregiver D stated, "If we had more activities, we would have less [resident] behaviors." On 01/24/2024 at approximately 10:45 AM, Surveyor interviewed Caregiver C who stated they do not do any activities with residents like the activity calendar says. On 01/31/2024 at approximately 11:00 AM, Surveyors interviewed Director A who verified activities were not being completed as scheduled and residents with memory care would benefit from an activities program. Director A indicated s/he was approved by Human Resources to hire a part time activities staff in the future.	{N 427}		

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{N 427}	Continued From page 68 Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0426 DHS 83.38(1)(b) Supervision	{N 427}		
N 433	83.38(1)(i) Behavior management. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide services to manage behaviors that may be harmful to themselves or others for 3 of 3 (Resident 7, Resident 8, and Resident 10) residents reviewed. Resident 7 had a history of physical and verbal aggression towards staff, visitors, and other residents. Surveyors observed Resident 7 to be exit seeking, be physically aggressive towards staff and other residents, and be verbally aggressive towards staff, other residents, and Surveyor. Resident 7's record did not include interventions for staff to use to redirect, support and mitigate Resident 7's behaviors. Resident 8 was found by staff in other resident rooms laying in beds, urinating in garbage cans or on another resident's face, and having physical	N 433		

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altercations with other residents. Resident 8's individual service plan (ISP) did not address these behaviors, including interventions for staff to use.

Resident 10 physically aggressed towards Resident 3, Resident 4, Resident 11, and Resident 12. The provider did not complete an investigation of the incident. Resident 10's record did not identify or address specific behaviors, including interventions for staff to support him/her.

Findings Include:

On 03/05/2024 and 03/06/2024, the department received complaints regarding resident to resident behaviors.

On 03/14/2024, Surveyors conducted an onsite visit to the facility. Surveyors requested the resident records of Resident 7, Resident 8, and Resident 10. The following was noted:

Resident 7
On 01/30/2024, Surveyor reviewed Resident 7's record and noted s/he was admitted to the facility on 10/07/2022 with diagnoses of mental disorder, depression, anxiety disorder, and osteoarthritis.

Surveyor reviewed Resident 7's most recent ISP with print date 01/24/2024 and noted Resident 7 had a legal guardian to make his/her decisions, required "24-hour supervision", and needed assistance to make his/her needs known. Resident 7 required assistance from staff for personal cares. Surveyor noted: "PSYCHOTROPIC MEDICATIONS - USING ... Using psychotropic medications related to specific behaviors: See MAR [medication

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N 433	Continued From page 70 administration record] for medications ... WANDERING/ELOPEMENT - SUPERVISION [Behavior Patterns/Wandering Risk] Directions: Provide supervision and redirection to avoid and prevent wandering episodes. If wandering occurs, determine follow-up plan. Schedule: Daily.. as needed. Resident's Needs/Preferences: To receive full supervision and redirection from staff to avoid and prevent wandering episodes. Resident's Desired Goals & Outcomes: To maintain low level of wandering episodes ... BEHAVIOR MONITORING [Mental Health/Attitude] Directions: Provide supervision and assistance in preventing and redirecting suicidal thoughts and behaviors. Report and document incidents for proper provider. Schedule: Daily @ 5:45 AM, 1:45 PM, 9:45 PM, As Needed. Resident's Needs/Preferences: Receiving supervision and assistance in all areas of preventing and redirecting suicidal thoughts and behaviors. Resident's Desired Goals & Outcomes: To receive assistance from staff and from proper provider (i.e. psychiatrist) when necessary... ACTIVITY PARTICIPATION MONITORING [Social Participation/Leisure Time Activities] Directions: Document participation with leisure time activities ...Resident's Desired Goals & Outcomes: To ensure they are participating in activities daily to maintain both mental and physical health." Surveyor reviewed Resident 7's "Care History" dated 01/01/2024 through 01/24/2024 and noted behavior monitoring was not documented 3 times a day and as needed. Surveyor noted documentation of behavior monitoring on 01/21/2024 at 8:26 PM - "What thought or behaviors were exhibited? Had some outburst	N 433		

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and yelling at other residents today but was able to get [him/her] to calm down. What assistance was required? NA [not applicable]"

Surveyor reviewed Resident 7's observation notes completed by provider staff and noted 1 note from 01/01/2024 through 01/24/2024. 01/06/2024 "Resident is getting more demanding with staff and other residents."

On 01/24/2024 at approximately 8:35 AM, Surveyors observed Resident 7 to present agitated and argumentative. S/he was yelling, using profanity, and questioning staff repetitively, pushing his/her walker forcefully into chairs and into staff, refusing to use his/her walker, and asking other residents to assist him/her. At approximately 9:19 AM, Surveyors observed Resident 7 pushing his/her walker into another resident's walker, yelling out at residents, and arguing with another resident while multiple residents were sitting in the dining room for breakfast. Surveyors observed Caregiver D redirect Resident 7 to another table with his/her walker. Surveyors observed Resident 7 to exit seek at the front door 7 times and the back door 2 times from approximately 8:40 AM to 12:00 PM. Resident 7 yelled at Surveyor to let him/her out the door. Surveyor observed Caregiver C and Caregiver D to attempt to redirect Resident 7 without success multiple times. Resident 7 continued to escalate.

On 01/24/2024 at approximately 8:45 AM, Surveyor interviewed Caregiver C. Caregiver C stated s/he was really on edge today. Surveyor inquired if this was normal for Resident 7 and Caregiver C said yes, s/he had good and bad days, and that today was a bad day. Surveyor inquired if Resident 7 wandered and was exit

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seeking often and Caregiver C said yes, s/he will go into other residents' rooms and try to get out of the facility frequently. Caregiver C indicated Resident 7 had PRN Lorazepam that they would give him/her if they couldn't de-escalate him/her. Caregiver C said Resident 7 would aggress towards other residents if his/her agitation escalated. Caregiver C said it was common for Resident 7 to be agitated during the day and Resident 2 was agitated in the evenings.

On 01/24/2024 at approximately 9:05 AM, Surveyors interviewed Director A who verified Resident 7 was very agitated today. Surveyors inquired if Resident 7 went into other residents' rooms and Director A said yes.

On 01/31/2024 at approximately 11:00 AM, Surveyors interviewed Director A and Administrator RN B who verified concerns with Resident 7's behaviors. Surveyor referenced Caregiver D stating that s/he felt residents would have less behaviors and go into other resident rooms less if they had time to supervise residents and provide activities. Director A stated "I absolutely agree." Director A verified Resident 7's behaviors were not well managed.

Resident 8
Surveyor reviewed Resident 8's closed resident record. Resident 8 was admitted to a sister facility on 09/21/2020 with diagnoses to Alzheimer's Disease, early onset and hyperlipidemia. Resident 8 recently moved to this facility from sister facility across the street, but staff can not provide a date when the move occurred. Resident 8 has an activated HCPOA. Resident 8's most recent individual service plan (ISP) dated 03/18/2024 indicated Resident 8 is independent with ambulation and transferring. The ISP

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indicated Resident 8 has been identified as a wandering risk due to wandering into other resident's rooms but has no previous occurrences of elopement. Resident 8 was to be checked on every two hours at night to ensure safety. The ISP also stated that Resident 8 required redirection and documentation of all behaviors. Resident 8 was displaying combative behaviors with staff and residents, has been wandering in other resident rooms and has been urinating in inappropriate places. The ISP stated to have interventions in place that help alleviate behaviors but did not include what those interventions should be. Resident 8 was discharged from the facility on 03/08/2024.

On 03/18/2024, Surveyor requested all recent assessments for Resident 8 from the facility. Surveyor was provided with Resident 8's most recent ISP. Nothing further for assessments was provided for Resident 8.

A review of Resident 8's facility observation notes stated the following:
-01/26/2024 at 7:45PM, "The resident was following and staring at other [fe/male] residents and went inside their rooms."
-02/02/2024 at 8:45PM, "It took over an hour to get [Resident 8] out of soiled clothes and had to take [his/her] garbage can and wash it do [sic] to [him/her] urinating in it while no one was looking. [Resident 8] is also hiding urine filled cloths [sic] in [his/her] closet on the top shelf as well and it drips on the other cloths[sic] hanging up. We told [Resident 8] goodnight and as we where[sic] getting ready to exit [his/her] room [s/he] raised [his/her] at both of us2, was going to swing and began to laugh thinking it was funny to show aggressive behavior."
-02/08/2024 at 8:45PM, "2/7/24 1st shift had

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issues changing resident and I was able to change [him/her] without issues, Resident had a shower, 100%[percent] food was eaten, Sat in the common area with other residents to watch tv 2/8/24 showed some aggressive behavior, profanity towards caregiver, was trying to enter other residents rooms, 100% food was eaten, refused to let me change [his/her] cloths."
-02/09/2024 at 9:30PM, "Resident keeps going by [Resident 3] and going in [his/her] room when the door is unlocked. [Resident 3] seems to be scared to go in [his/her] room and go to bed now because [Resident 8] keeps going by [his/her] door and trying to get in [his/her] room when its locked."
-02/10/2024 at 1:45PM, "Resident was seen urinating on [his/her] wall after being fully changed into clean clothes"
-02/11/2024 at 2:00PM, "Resident has been making the [wo/men] in the facility feel uncomfortable by walking into their rooms or being on the outside...Also showing strange behaviors such as urinating in [his/her] garbage can."
-02/12/2024 at 3:15PM, "Resident was asked not to go down the [fe/male] hall and [his/her] reply was [expletive] you and then smiled and made a fist and stiffened upper torso"
-02/23/2024 at 3:45PM, "Resident had peed on bedroom wall writer's coworker found resident sitting on bed with pants down after resident had peed on wall"
-02/26/2024 at 2:30PM, "Resident was asked to come and change [his/her] clothes before [s/he] sits down. Resident then lunged at me with fist drawn and a angry look on [his/her] face. This behavior was witnessed by a social worker and by a worker leaving. This has been several times now since coming over to this building. Management has been told of this behavior

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several times. The social worker siad this is very scary behavior. [S/he] even stepped away from [Resident 8]...I have asked to have [him/her] re-evaluated since [s/he] came over here before it gets worse, but so far nothing."
-03/04/2024 at 6:15AM, written by Director A "While doing rounds staff member seen [Resident 8] in [Resident 4's] room where [s/he] was observed urinating on [Resident 4's] bed. Resident redirected [Resident 8] back to [his/her] bedroom with no further altercations."
-03/06/2024 at 3:15AM, written by Director A stated, "Staff heard screaming from [Resident 4's room]. [Resident 8] was on top of [Resident 4] attempting to have sexual intercourse. [Resident 8] had [his/her] pants off and [Resident 4's] shirt off. [Resident 4] still had [his/her] brief on and [Resident 8] had [his/her] legs up on [his/her] shoulders. As staff member intervened to remove [Resident 8] from [Resident 4's] bed, [Resident 8] bit staff members hand and bend[sic] staff's finger back where it dislocated. Staff removed [Resident 8] from [Resident 4's] room and managed to get [him/her] back to [his/her] own room. Staff observed scratch marks on [Resident 8's] face from the victim fighting back.
-03/06/2024 at 11:15PM, "Approximately at 11:20 resident came out of [his/her] room and threw a chair onto the floor. I spoke to resident in a calm manner and asked resident to come and sit on couch and watch some TV. Resident sat on couch and within a minute [s/he] knocked over the end table..."
-03/08/2024 at 9:34AM, "[Resident 8] was discharged from the system."

Surveyor reviewed Resident 8's physician notes. The following was noted:
-On 01/31/2024, RCC L wrote to physician, "Staff informed me today that resident has been having

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a huge increase in behaviors. [S/he] is threatening to hit staff. They also said [s/he] seems to get worse after [his/her] family leaves."
-On 02/02/2024, NP (Nurse Practitioner) V wrote an order to discontinue current Sertraline (antidepressant) order and start Sertraline 100mg(milligrams) 1 tablet four times a day for anxiety/depression.
-On 02/29/2024, NP V wrote, "[Resident 8] was seen today for [his/her] monthly visit. No change necessary to POC[plan of care] today.
-On 02/29/2024, Behavioral Health saw Resident 8 and wrote, "Visited with pt [patient] privately in room. Patient has had a decrease in behaviors over the past month and appears to be adjusting better to [his/her] new setting. [S/he] does still continue to wander in the evening and at times can be verbally aggressive if the approach isn't correct. No other concerns noted."
-On 03/04/2024 at 10:48AM, Administrator RN B wrote to physician, "Letting you know that [Resident 8's] behaviors have increased over the past 2 weeks. Last night [s/he] was found urinating on a resident face during the night. Please look at meds to see if any adjustments are needed. Thanks"
-On 03/04/2024 at 3:02PM, NP V wrote, "[His/her] medication was increased at the beginning of February. It takes 6 weeks for full effect. [His/her] behaviors have been better and [s/he] seems to be adjusting to the new building better now. Do you know why [s/he] was doing this? Does [s/he] typically sleep well at night? Is there a pattern?"
-On 03/06/2024 at 2:14PM, Administrator RN B wrote, "[Resident 8] had another altercation with another resident this morning. [S/he] went into a [male/female] resident room and took off [his/her] clothing and tried having sexual relations with [him/her]. [S/he] also threw another [male/female] resident onto the floor. Please advise what orders

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you want for him/her. UA [urinalysis] with c/s[culture/sensitivity], Geriatric psych eval? Medications adjusted? Please advise asap. Thanks."
-On 03/06/2024 at 2:17PM Administrator RN B wrote, "Normally [s/he] does sleep well. There is no pattern."
-On 03/06/2024 at 4:12PM APNP (Advanced Practiced Nurse Practitioner) DD wrote, "Let's start with the UA[urinalysis] to rule that out...."
-On 03/07/2024 at 9:28AM lab ordered

On 03/14/2024 at approximately 10:40AM, Surveyor interviewed Administrator RN B. Administrator RN B stated Resident 8 was "always quiet, always pleasant." Resident 8 would just smile and nod "yes" when talking to him/her. Administrator RN B stated that Resident 8 lived at sister facility across the street until recently, Administrator RN B could not recall the exact date of the move but it was probably a month or 2 months ago. Resident 8 moved because of his/her advancing dementia and the his/her interactions with other residents "wasn't there anymore." Administrator RN B stated s/he would "fit in better over here." Administrator RN B stating there had been no reports of Resident 8 urinating in garbage cans or exit seeking at the sister facility.

Resident 10
On 03/04/2024, the department received self-report information from Administrator RN B reporting on 03/01/2024 at approximately 4:00 AM, Caregiver I witnessed an incident involving Resident 4, Resident 10, and Resident 11. Resident 4 had gone into Resident 10's room, woke him/her, and stole his/her remote. Resident 10 followed Resident 4 to the common area and they started fighting. Resident 10 hit Resident 4

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on the side of his/her face and s/he fell to the floor. Resident 11 got up to defend Resident 4 and s/he was struck in the left eye. Staff separated residents. Residents were escorted back to their rooms. Administrator RN B was notified in the morning and assessed residents. Resident 4 and Resident 10 did not have any injuries. Resident 11 had a black and blue left eye.

On 03/19/2024, Surveyor reviewed Resident 10's record and noted s/he was admitted to the facility on 02/20/2024. Resident 10's record did not include any listed diagnoses. Per Resident 10's medication list, Resident 10 was on various psychotropic medications for tardive dystonia, anxiety, depression, and insomnia.
Surveyor reviewed Resident 10's assessment dated 02/19/2024 and noted the following: "Destructive/Abuse - Supervision ...Displays no destructive/abusive behaviors ...
Interaction - Independent ...None, resident displays positive interaction with others independently and without incident ...
Aggressive/Combative - Independent ...None, resident displays no aggressive/combative behaviors." No other assessments were maintained in Resident 10's record.

Surveyor reviewed Resident 10's ISP with print date 03/14/2024 and noted the following: "MEDICATION MANAGEMENT - ASSIST ...Needs assistance administering medications ...
PSYCHOTROPIC MEDICATIONS - USING ...Using psychotropic medications related to specific behaviors ...Resident's Desired Goals & Outcomes ...Resident behaviors to be controlled as allowed by progression of disease process ...
2 HOUR NIGHT TIME CHECKS ...Staff to check on resident every TWO hours at night to ensure

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safety and brief is dry and clean. Resident and residents' family would like door locked at night to prevent wandering residents from entering room while sleeping...
BEHAVIOR MONITORING [Mental Health/Attitude] ... Provide redirection and documentation of any behaviors ...Resident requires redirection and documentation of any behaviors. Resident has a history of behaviors and combative when [s/he] is exhibiting anxiety or is upset ...
AGGRESSIVE/COMBATIVE - INDEPENDENT ...Resident requires redirection and documentation of any combative behaviors. Resident does have a history of being combative when [s/he] has anxiety or upset."

Surveyor reviewed Resident 10's observation notes completed by provider staff dated 02/19/2024 to 03/14/2024 and noted:
-02/20/24 10:45 PM "Refused dinner when offered, toileted, laid down in bed"
-02/21/24 9:45 PM "Anxious, ate dinner, changed into night cloths [sic], wasn't feeling well, shaky, had a hard time walking, put into bed."
-02/22/24 10:30 PM "During dinner resident was shaking aggressively, confused, got resident back to room was losing balance even with walker, lost balance well toileting, changed into night cloths and put into bed."
-02/24/24 4:00 PM "resident is showing weird signs with writer playing with private area when engaging in conversation. Id [sic] watch out for it."
-02/26/24 4:00 PM "Resident was in bed all night. Checked every 2 hours. [S/he] got upset when writer attempted to check brief or wake [him/her] to ask if [s/he] needed to use the bathroom."
-02/29/24 9:30 PM "Resident was very on edge tonight. Came down for supper, but told us [s/he]

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doesn't eat this crap. Was given a clonazepam and a lorazepam. Calmed down after a while, then continuously asking, what are we going to do for these people, they need a special meal. Gave [him/her] trazodone ..."
-03/01/24 11:30 AM "Event Notes: I heard a lot of screaming yelling [sic] when I arrive in the common area it was a brawl with 3 other [fe/male] residents. It last [sic] for about 2 minutes. I separated all of the residents that were involved no other altercations occurred the rest of night."
-03/02/24 4:45 AM "Resident was aggressive toward writer each time I went in [his/her] room to check/change [him/her]. Was not able to do any cares as [s/he] was trying to punch and getting physical."
-03/04/24 7:00 PM "Resident and residents' family would like door locked at night to prevent wandering residents from entering room while sleeping. Make sure to relockdoor after 2 hour checks." [written by Director A]
-03/07/24 5:45 AM "Resident was checked every 2 hours. Refused all cares. At 4 am check resident tried to punch staff during refusal [sic]."
-03/10/24 9:45 PM "Resident refused night cares and getting into bed."
-03/14/24 4:30 AM "Resident was in bed all night. Refused all cares. Said [s/he] just wanted to sleep."
Surveyor note: Resident 10's assessment and ISP did not identify Resident 10 to have a history of or interventions related to refusals of medications, refusal of cares, preferences with sleep schedule, shaking, needed approaches for care, and symptoms of anxiety. The ISP was updated to reflect Resident 10 had behaviors, but did not identify Resident 10's specific behaviors s/he was exhibiting and specific interventions to support Resident 10.

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N 433	Continued From page 81 Surveyor reviewed Resident 10's incident report for the incident on 03/01/2024 completed by Caregiver I and noted "What did the Resident state happened? Resident said [s/he] was sleep walking don't [sic] remember attacking people." On 03/14/2024, Surveyor reviewed Resident 4 and Resident 11's incident reports for the incident on 03/01/2024, completed by Caregiver I. Resident 4's incident report: "I seen [Resident 4] getting hit at a rapid pace in the face at the time my back was turn [sic] doing 2 hour checks when I got back to common area [Resident 4] was on the ground crying. I help [sic] [Resident 10] back to [his/her] room but [s/he] was scared stayed [sic] in [his/her] room the whole night." Resident 11's incident report: "[Resident 11] could not tell me what happened ...The resident was hit in the face started [sic] to fight back with [Resident 10] my back was turn [sic] when I was doing 2 hour checks caught [Resident 11] tussling with [Resident 10] [s/he] did defend [him/herself] by throwing punches back." Surveyor noted Resident 4, Resident 10, and Resident 11's records did not include any additional documentation regarding the incident and any other information leading up to the incident. On 03/14/2024 at approximately 9:00 AM, Surveyor and Caregiver M went to Resident 10's room. Surveyor observed Resident 10 to be laying in his/her bed and was startled by Caregiver M and Surveyor's presence. Surveyor attempted to introduce him/herself and Resident 10 started shaking with tremors and presented distraught by Surveyor's presence. Surveyor	N 433		

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asked Resident 10 if s/he preferred him/her to leave and Resident 10 stated yes. At approximately 10:30 AM, Surveyor attempted to meet with Resident 10 again without success. Caregiver M indicated it was common for Resident 10 to be nervous and startled by new people.

On 03/19/2024 at approximately 5:00 PM, Surveyor interviewed Power of Attorney for Health Care (POAHC) EE who stated s/he knew Resident 10 had diagnoses of dystonia and bipolar II. S/he said s/he didn't know if in fact s/he had dementia, but that's what facility staff tell him/her. S/he described Resident 10 as a "no" person and that a positive, "we're going to do this" approach was important to take with him/her. POAHC EE said s/he was aware of a few times where s/he refused medications due to time of day, but it was resolved. S/he was not aware of Resident 10 refusing cares or having increased anxiety. Surveyor shared his/her experience attempting to meet with Resident 10. POAHC EE shared Resident 10 had been changing quite a bit over the past few months and was very concerned about his/her prognosis.
POAHC EE shared the recording of a voicemail with Surveyor which was left by Caregiver D on 03/01/2024 at 7:07 AM. The voicemail stated "[Resident 10] had a situation last night where [s/he] was; [s/he] became very physical with 5 [fe/male] residents where [s/he] ended up hitting them - if you could give me a call." POAHC EE indicated Caregiver D wasn't the staff who witnessed the incident, so s/he voiced frustration of getting second-hand information. POAHC EE stated when s/he arrived to the facility the morning of 03/01/2024, s/he talked with Director A who told him/her a different story. POAHC EE stated Director A indicated his/her understanding

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was that someone entered Resident 10's room which may have scared Resident 10. The other resident took [his/her] remote and then there was a confrontation between Resident 10 and 2 other residents. POAHC EE said Director A had said there was a potential that Resident 10 hit the other resident. Director A told POAHC EE that they were starting an investigation and s/he can't share anything else. POAHC EE said s/he heard multiple different stories about the night from others and stated "I don't even know if [Resident 10] actually hit someone. S/he has heard there were 2 others, 3 others, and 5 others involved, but no verification of any. S/he said Resident 10 does not recall being up at all that night. POAHC EE was told by Director A and Administrator RN B that "from now one we're going to be locking [his/her] door" so other residents can't get in. S/he said s/he did not request for his/her door to be locked. POAHC EE stated as of 03/19/2024, no one has still followed up with him/her about the incident on 03/01/2024 and no other information was provided about Resident 10's behaviors and if s/he had them. POAHC EE indicated s/he felt like information was being intentionally kept from him/her.

On 03/14/2024 at approximately 10:40 AM, Surveyors interviewed Administrator RN B who reported early in the morning, Resident 4 had woken Resident 10 up and had grabbed his/her remote. Resident 10 had confronted Resident 4 in the hallway and "they got into a brawl;" Resident 4 ended up on the ground. Administrator RN B stated Resident 11 overheard the commotion and then got involved. Administrator RN B indicated s/he believed Caregiver K was doing rounds and had heard the altercation and came to see what it was. S/he then broke the altercation up. Surveyors inquired

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whether Resident 4, Resident 10, and Resident 11 received or required medical evaluation and intervention. Administrator RN B stated s/he assessed the residents in the morning and did not find any injuries requiring further medical evaluation, but Resident 11 did have a black and blue eye. Surveyor inquired whether Resident 10 was intentional in his/her aggression and injuring Resident 11 and Administrator RN B stated s/he did not know. Surveyors inquired whether Adult Protective Services (APS) or law enforcement were contacted and Administrator RN B was unsure and stated "you'd have to talk to [Director A] if police or APS were notified." Surveyor inquired whether it was reported to them that 3 other residents were hit and/or injured by Resident 10. Administrator RN B stated s/he was not aware of any other incidents or affected residents.
Administrator RN B stated Resident 10 was a newer resident and did not have a history of physical aggression. Administrator RN B described Resident 10 as having "extreme anxiety" and it was important to approach him/her calmly. S/he indicated Resident 10 was easily startled and was anxious with new faces. Surveyor inquired if any assessments or interventions were implemented for the incident and s/he said residents were to be checked on every 2 hours and Resident 10's spouse requested for his/her door to be locked. Administrator RN B stated Resident 4 was known to go into other resident's rooms and wandered the halls throughout the night. Administrator RN B stated Resident 11 was up at night at times, but it was not normal for him/her to express aggression towards others.

In conclusion, Resident 10 was witnessed physically aggressing towards Resident 3,

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N 433	Continued From page 85 Resident 4 and Resident 11. An investigation was not completed to identify factual information or a timeline of events. The provider did not assess Resident 10 since admission despite a change. Resident 10 was identified to have various behaviors and a known resistive demeanor. Resident 10's ISP was not updated to reflect specific behaviors, needs, and interventions to support Resident 10. On 03/21/2024 at approximately 8:30 AM, Surveyors interviewed Director A, Administrator RN B, and Regional Director Y who acknowledged Resident 8 and Resident 10's behaviors were identified, assessments were not completed, and behaviors were not followed up on or documented in Resident 8 and Resident 10's records. Cross Reference: N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment N0426 DHS 83.38(1)(b) Supervision N0427 DHS 83.38(1)(c) Leisure Time Activities	N 433		
{N 481}	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by:	{N 481}		

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{N 481}	Continued From page 86 Based on observation and interview, the provider did not provide a living environment that was safe, clean, comfortable and homelike. This is a repeat deficiency, see Statement of Deficiency (SOD) P4Z912, dated 09/26/2023. Findings include: On 01/02/2024, 01/03/2024, and 01/10/2024, the department received complaint information alleging the facility was unclean. On 01/24/2024, Surveyors conducted a verification visit. On 01/24/2024 at approximately 8:45 AM, Surveyor toured the facility. Surveyors observed the following: -Resident 3's room had crumbs and debris throughout the carpet and bathroom floor. -Resident 4's room carpeting had splotchy yellow stains spanning from the entrance of his/her room to approximately 6 1/2 feet into his/her room and up to a foot in width. Surveyor noted a brown circular spot next to the yellow stains. -The unlocked laundry room had 5 overflowing laundry baskets of clothes and 2 empty laundry baskets in the immediate entrance of the laundry room blocking off the washer and dryer. The floor had debris and lint on it. Behind the dryers was debris, used dryer sheets, wads of lint, crumpled paper, used gloves, miscellaneous debris and dust, a large disassembled cardboard box, and an empty box of dryer sheets. -The furnace room located in the right resident room hall from the entrance was unlocked and had visible debris, papers, garbage, and hard water stains on the floor. -The hair salon located in the right resident room	{N 481}		

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{N 481}	Continued From page 87 hall from the entrance was unlocked and had a large pile of human hair and other debris on the floor. -The private dining room located directly off of the common area dining room had green stains on the floor and multiple chair markings. The room was approximately 80 degrees Fahrenheit and required provider staff to open a window. Surveyor noted it was approximately 32 degrees Fahrenheit outside on his/her drive to the facility. -2 lines of piping covered by black insulation and metal clamps stretching across the entirety of the common dining room lentil from the kitchen to the hallway. The piping was drooping in multiple places. -Visible thick dust on the dining room ceiling vent and surrounding it. -Dust on the air return vent on the dining room ceiling. -Brown food-like splatter on the wall directly in front of the front entrance vestibule. -Stains and markings on the common area chair and side table. -Debris on the common space window sills, and the carpeting of the hallway, common space, and resident rooms. -No door on the oven in the kitchen Surveyors were at the facility until 3:45 PM and did not observe staff cleaning resident rooms or the common area for the entirety of the visit. On 01/24/2024 at 9:00 AM, Surveyor interviewed Director A. Director A stated they are getting a housekeeper. It has been approved through upper management. Director A stated there are 2 individuals interested and will be starting next week. They will work 3 days a week, Monday, Wednesday and Friday. Director A stated caregivers are currently doing the cleaning in	{N 481}		

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{N 481}	Continued From page 88	{N 481}		

each house. Director A stated night shift is supposed to be mopping daily and caregivers on other shifts should be taking garbage out of resident rooms and vacuuming. Director A stated, "Cleanliness is everyone's job."

On 01/24/2024 at approximately 12:45 PM, Surveyor interviewed Resident 5. S/he stated his/her room could use a good vacuum and the bathroom could be dust mopped currently. Resident 5 stated s/he felt the staff could clean more often. Surveyor observed Resident 5's room carpeting had crumbs and debris throughout the carpet and bathroom floor. His/her bathroom and bedroom garbage cans were overflowing with garbage.

On 01/31/2024 at approximately 7:30 AM, Surveyor interviewed Guardian G who stated s/he had concerns about Resident 5's room not being cleaned often enough. S/he reported seeing on multiple occasions Resident 5's bathroom and bedroom garbage overflowing, the room having crumbs throughout the carpet, and his/her bathroom being unclean and odorous.

On 01/24/2024 at approximately 9:45 AM, Surveyor interviewed Resident 6 who stated s/he wished staff would clean his/her room more often. S/he shared s/he bought a vacuum for his/her room for staff for convenience, but his/her friend ends up using it and cleaning his/her room instead. Resident 6 stated s/he prefers things to be tidy and organized. Surveyor observed Resident 6 to be confined to a wheelchair. Surveyor observed Resident 6's bathroom counter to have piles of personal hygiene products over the entirety of the bathroom sink.

On 01/24/2024 at approximately 1:45 PM,

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{N 481}	Continued From page 89 Surveyors interviewed Caregiver D who stated there was "not enough time to do what they need to. Rooms are not up to par the way they should be and laundry is not done enough. I wouldn't want to be in a room like this. Every room needs a good deep clean and carpet cleaning." On 01/29/2024 at 2:20 PM, Surveyor interviewed Director A. Director A stated scheduled cleaning occurs on the night shift (11:00 PM - 7:00 AM). Caregivers on this shift are to be doing scheduled facility cleaning which would include mopping the dining room, vacuuming common areas, dusting, etc. Director A stated, "everybody is a housekeeper" on the other shifts. Caregivers on the other shifts should be emptying garbages in resident rooms, vacuuming floors if they see it is dirty, and cleaning bathrooms as needed. On 01/30/2024, Surveyor reviewed the provider's "Daily NOC [night] shift duties." Surveyor noted: "1. Sweep and mop kitchen, dining room, pantry, and entryway floors. 2. Sweep and mop under the large 3 bin sink. 3. Vacuum entryway rugs and living room carpet (this does not bother the residents) ..." On 01/31/2024 at approximately 11:00 AM, Surveyors interviewed Director A who verified cleanliness was a concern and a work in progress. Director A stated they are in the process of hiring a housekeeper to help with the duties. Director A and Administrator RN B acknowledged the concerns of the facility not being a safe, clean, and homelike environment. On 03/14/2024 from approximately 9:00 AM to 11:45 AM, Surveyors conducted an additional onsite visit at the facility. Surveyors noted the following:	{N 481}		

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{N 481}	Continued From page 90 -Resident 10's bathroom was odorous like urine and his/her toilet had feces remnants in it. Resident 10's bathroom garbage was overflowing with incontinence products and the carpeting had debris. On 03/19/2024 at approximately 5:00 PM, Surveyor interviewed POAHC EE who reported multiple concerns about Resident 10's room not being cleaned and multiple occassions where his/her toilet had feces still in it when s/he arrived. POAHC EE stated his/her room smelled like urine regularly as his/her room was not cleaned up as it needed to be with Resident 10's incontinence. -Resident 11's bathroom was odorous like urine. On 03/18/2024 at approximately 3:30 PM, Surveyor interviewed POAHC FF who stated him/her and his/her family members take turns cleaning Resident 11's room and bathroom as the facility will not do it. POAHC FF indicated Resident 11 was incontinent and his/her room would be very dirty and odorous if they did not clean it as the facility did not provide housekeeping. -Resident 12's room and bathroom flooring had multiple areas of debris, the bathroom and shower floors had stains, his/her garbage was overflowing with multiple soiled depends and chux pads, used napkins were on the bathroom floor, the wall next to the bathroom mirror had damaged drywall from where something was hanging, there was dried feces on the wall below the bathroom sink, an unused toilet paper dispenser was on the floor below the bathroom sink, the cover of a commode was on the floor in the bathroom, and his/her soiled and odorous laundry was overflowing in the basket. On 03/14/2024 at approximately 9:30 AM, Surveyor interviewed Hospice Aide GG who	{N 481}		

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{N 481}	Continued From page 91 stated housekeeping was never done in Resident 12's room. S/he indicated s/he had asked staff to empty his/her garbage and to do his/her laundry since the basket was overflowing and there were soiled clothing in it on 03/13/2024 (the day prior) and neither had been done. Hospice Aide GG stated the bathroom was never mopped or cleaned and the feces on the wall below the sink had been on there for multiple months. -Resident 13's room was odorous like urine, bed sheets had a large wet circle noted on them, bathroom garbage contained several soiled incontinence products. On 03/14/2024 at approximately 9:30 AM, Surveyor interviewed Caregiver E. Caregiver E stated Resident 13 doesn't let people change him/her. Resident 13 will sleep in urine soaked pants and s/he will say s/he is "just a little wet." Caregiver E confirmed Resident 13's room was of odorous of urine. -Resident 14's room was odorous like urine and had a very pungent smell of body odor, bathroom had smeared brown stains on the floor. On 03/14/2024 at approximately 9:30AM, Surveyor interviewed Caregiver E and Caregiver M. Caregiver E stated Resident 14 hasn't changed his/her clothes in over a month. Caregiver E stated yesterday, Resident 14 urinated in his/her pants and will wear those same pants today. Caregiver M stated Resident 14 will spit phlegm on his/her bedroom floor. Caregiver M stated s/he has had to clean up the phlegm numerous times. Caregiver E stated Resident 14 will urinate and defecate on the floor of his/her bathroom. Caregiver E indicated Resident 14 refuses to let staff help him/her. Caregiver E and Caregiver M verified the pungent smell coming from Resident 14's room.	{N 481}		

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{N 481}	Continued From page 92 On 03/21/2024 at approximately 8:30 AM, Surveyors interviewed Director A, Administrator RN B, and Regional Director of Operations Y. Regional Director of Operations Y verified housekeeping and maintenance was still a work in progress. Cross Reference: DHS 83.45(3) Toxic Substances	{N 481}		
{N 499}	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds, polishes, and toxic substances were labeled and stored in a secure area. This is a repeat deficiency, see Statement of Deficiency (SOD) P4Z912, dated 09/26/2023. Findings include: On 01/24/2024, Surveyors conducted a verification visit. On 01/24/2024 at approximately 8:45 AM, Surveyor toured the facility. Surveyor observed a room identified as a "Hair Salon" located in the hallway of resident rooms to the right of the common space and main entrance. The salon door was unlocked. Surveyor observed a spray	{N 499}		

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{N 499}	Continued From page 93 can of WD-40 on the shelf at average height eye level when entering the room. Surveyor observed a laundry room located in the hallways of resident rooms located to the left of the common space and main entrance. The laundry room door was unlocked. Surveyor observed a housekeeping cart with: a handwritten labeled bottle of furniture polish, a jug of carpet cleaner concentrate, a bottle of odor fabric freshener, Clorox wipes, 1 jug of 3-in-1 carpet cleaner concentrate, a bottle of dish soap, Comet deodorizing cleanser powder with bleach, and a bottle of toilet bowl cleaner. On the wall next to the housekeeping cart, Surveyor observed multiple dispensers that contained: Odor fabric freshener, hard surface sanitizer, neutral disinfectant, glass & multi-surface cleaner, neutral floor cleaner, and heavy duty floor cleaner/degreaser. On the shelves located above the washing machine, Surveyor observed: 2 cans of oven and grill cleaner, a jug of Drano pipe cleaner, 2 bottles of furniture polish, 3 bottles of laundry detergent, 1 container of laundry detergent pods, Clorox wipes, a jug of Clorox bleach, 7 jugs of Super Trump detergent for machine washing, 3 bottles of toilet bowl cleaner with "Keep Out of Reach of Children DANGER" label, 2 jugs of heavy duty tile grout cleaner, and 2 jugs of concentrated 3-in-1 carpet cleaner compound with "Warning Keep Out of Reach of Children" label. Surveyor noted a sign on the laundry room door that stated, "Please keep door closed at all times," and a keypad on the door. Surveyor noted the door did not lock behind him/her when s/he left the laundry room.	{N 499}		

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{N 499}	Continued From page 94 On 01/24/2024 at approximately 1:00 PM and 3:15 PM, Surveyor observed the salon and laundry room to remain unlocked. On 01/31/2024 at approximately 11:30 AM, Surveyors interviewed Director A and Administrator RN B who acknowledged toxic substances were not stored in a secured area.	{N 499}		
{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, the provider did not ensure tornado, flooding, or other emergency or disaster evacuation drills were conducted at least semi-annually in 2023. This is a repeat deficiency, see Statement of Deficiency (SOD) P4Z912, dated 09/26/2023. Findings include: On 01/24/2024, Surveyors conducted a verification visit. On 01/24/2024 at approximately 9:00 AM, Surveyors interviewed Director A who stated s/he would ask the maintenance staff for the other evacuation drills and the plan for it. At approximately 11:00 AM, Surveyor reviewed provider's documentation of a fire drill. Surveyor noted there was no evidence of other emergency or disaster evacuation drills conducted in 2023.	{N 526}		

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{N 526}	Continued From page 95 On 01/24/2024 at approximately 2:30 PM, Surveyor inquired with Director A whether any other evacuation drills were conducted in 2023. Director A stated s/he did not know. Surveyor inquired with Director A if they had a policy or plan for evacuation drills to be conducted in 2024. Director A stated s/he said they did and would get Surveyor a copy. On 01/24/2024 at 3:45 PM, 01/25/2024 at 10:03 AM, 01/29/2024 at 8:40 AM, and 01/30/2024 at 8:45 AM, Surveyor requested a copy of other evacuation drills in 2023 or a policy/plan to conduct an other evacuation drill. On 01/31/2024 at approximately 11:00 AM, Surveyors interviewed Director A and Administrator RN B. Director A stated the maintenance person "would have the information on the other evacuation drills, I don't know when they are done or what." Director A stated s/he would send Surveyor a copy of what the maintenance man had. As of 02/01/2024, Surveyors did not receive any verification of an other evacuation drill conducted in 2023 or a plan to conduct them.	{N 526}		
N 654	83.59(4)(f) Delayed egress: department approval Delayed egress door locks are permitted with department approval only in facilities with a supervised automatic fire sprinkler system and a supervised interconnected automatic fire detection system and shall comply with all of the following: To obtain department approval, the CBRF shall demonstrate that delayed egress equipment is necessary to ensure the safety of residents served by the CBRF, specifically	N 654		

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N 654	Continued From page 96 persons at risk of elopement due to behavioral concerns, cognitive impairments or dementia, including Alzheimer ' s disease. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not demonstrate to the department the delayed egress equipment was necessary to ensure the safety of the residents served by the CBRF and obtain department approval for delayed egress doors. Findings include: The facility is licensed to provide services for up to 22 residents who may be physically disabled, advanced aged, terminally ill, and/or have Alzheimer's/dementia. On 01/24/2024, Surveyors conducted an onsite visit. At approximately 8:45 AM, Surveyor toured the facility and observed an exit door at the end of a resident room hallway located to the right of the main entrance. Surveyor noted the door had a lit-up "EXIT" sign with emergency lights above it. The door had a key pad next to it and a sign that said "EMERGENCY EXIT ONLY - ALARM WILL SOUND IF DOOR IS OPENED." Surveyor noted the door was locked when s/he attempted to open it. On 01/24/2024 at approximately 2:30 PM, Surveyor interviewed Caregiver C by the right hallway exit. Surveyor observed Caregiver C enter a code into the keypad and open it. Caregiver C guided Surveyor through the exit door into a small vestibule that led to an external door. Surveyor inquired if the exit was part of the provider's evacuation plan. Caregiver C said "I think so, but we never use it otherwise." Surveyor	N 654		

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N 654	Continued From page 97	N 654		

noted a shelf with incontinence products in the vestibule. On the external door, Surveyor and Caregiver C observed a mag lock in the top left corner of the door that was visibly disconnected. Surveyor observed a sign on the door that said "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS." Surveyor tested the external door and was able to open it immediately without delay.
Surveyor observed an evacuation plan map on the wall next to the keypad locked exit door and noted the external exit was identified as an exit in the evacuation plan.

On 02/02/2024, Surveyor reviewed the provider's most recent fire drill and noted the exit was utilized in the drill.

On 02/02/2024 Surveyor reviewed the department's provider record and was unable to locate any updated documentation to indicate or support that the provider had submitted the plan review.

On 02/02/2024 at approximately 12:53 AM, Surveyor interviewed Director A who stated the door at the end of the hallway was a delayed egress door. S/he indicated that the door was not locked and that it would release after 15 seconds. Director A stated all doors were delayed egress. Surveyor noted there was a disconnected mag lock on the external door, so inquired whether the lock moved to the internal door. Director A indicated the door setup had been that way since s/he started in November 2023, so was unsure what it had been before. Surveyor inquired whether there was any documentation from the Office of Plan Review (OPRI) regarding the inspection and testing of the delayed egress system and Director A was not sure.

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N 654	Continued From page 98 Director A acknowledged the door needed to have the label to identify it would open in 15 seconds and the delayed egress doors needed to be tested and approved by the department.	N 654		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure Resident 10 and Resident 12 received adequate and appropriate care within the capacity of the facility. Resident 10 required assistance with all activities of daily living (ADLs) including bathing, dressing, toileting, incontinence care, transferring, mobility, housekeeping, laundry, and meals. Resident 10 was not receiving regular checks and was found unchecked and soiled on numerous days.	Y3244		

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Y3244	Continued From page 99 Resident 12 required assistance with all activities of daily living (ADLs) including bathing, dressing, toileting, incontinence care, transferring, and housekeeping. Resident 12's hospice caregiver provided daily bathing and dressing in supplement for the provider not completing them. Findings include: On 03/04/2024, the department received complaint information alleging residents were not getting care to meet their needs. On 03/14/2024, Surveyors conducted a complaint investigation. RESIDENT 10 On 03/14/2024, Surveyor reviewed Resident 10's record and noted s/he was admitted to the facility on 02/20/2024. Resident 10 had an activated power of attorney. Surveyor reviewed Resident 10's individual service plan (ISP) with print date 03/14/2024. Surveyor noted - "BATHING - FULL ASSISTANCE... Provide full assistance bathing/showering. Assist with dressing and underessing, wash, shampoo, and with all required physical assistance... DRESSING - FULL ASSISTANCE... Assist choosing proper attire and with dressing/undressing... MEALS - COMMUNITY PREPARES...Resident requires community to prepare meals...Goals & Outcomes: To have nutritious meals that resident enjoys... TOILETING - FULL ASSISTANCE...Provide full assistance with toileting needs... Daily @ 6:00 AM, 10:00 AM, 2:00 PM, 6:00 PM, As Needed... MOBILITY & WALKING - FULL ASSISTANCE...Provide full assistance to resident with walking needs. Assist in morning and night	Y3244		

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Y3244	Continued From page 100	Y3244		

during wake-up and bed time...Requires full assistance including physical and verball assistance with walking needs. REquires hands-on assistance with helping stand up, helping use any walking devices, and helping sit down/lay down...
HOUSEKEEPING - ASSIST...Provide assistance with upkeep of room. Assist with all room care needsa nd all required physical assistance...
LAUNDRY SERVICE...Provide laundry needs. Gather dirty/soiled clothes/linen and wash/dry/fold and put away properly...
FALL RISK - HIGH... Resident is considered a high fall risk per fall risk assessment."

On 03/14/2024 at approximately 9:00 AM, Surveyor met Resident 10 and observed Caregiver M assisting him/her to take his/her medications. Resident 10's vicinity smelled like urine and s/he was still laying in bed. Caregiver M administered Resident 10's medications and laid him/her back in bed, and left the room. Surveyor noted Resident 10 was not assisted with cares while Surveyors were onsite, did not come to the common area, and was not in the dining room for breakfast. Surveyor did not observe any meal trays prepared or provided to residents.

On 03/19/2024 at approximately 5:00 PM, Surveyor interviewed Power of Attorney for Health Care (POAHC) EE. POAHC EE stated Resident 10 had a call light, but needs reminders and encouragement to use it. S/he stated staff are aware of this and said they would be checking on him/her, but don't. POAHC EE reported observing Resident 10 to have missed breakfast at least 3 days and staff did not offer or bring Resident 10 breakfast. POAHC EE stated how you approach Resident 10 was important on getting him/her to get up and going. S/he stated

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s/he always finds Resident 10 with soiled clothing on, laying in bed, and unclean. POAHC EE stated Resident 10 had lost control of his/her bladder and bowel, and so needed assistance getting to the bathroom and getting changed and cleaned up. S/he witnessed it not happening as s/he visited Resident 10 daily. POAHC EE recalled a day in the past week where when s/he arrived to Resident 10's room, s/he was sitting on the edge of the bed and s/he could visibly see urine coming up and over his/her depends. POAHC EE had to assist him/her to the bathroom to change. S/he said if staff saw him/her assisting Resident 10, they scold him/her, but POAHC EE felt that if s/he didn't do it, the staff wouldn't. POAHC EE stated s/he was told at admission that they would be looking in on him/her every 2 hours and s/he felt that was definitely not happening and did not happen while s/he was visiting ever. POAHC EE indicated s/he had pressed his/her call light numerous times and on numerous visits and the wait time was so long, s/he would have to go out and search a staff member down. Resident 10 had not had a shower yet since living at the facility (since 02/20/2024), but recently, s/he had demanded staff to shower him/her since s/he was so soiled. POAHC EE reported the following additional concerns: none of Resident 10's clothes in his/her closet are his/hers, clothes that s/he did purchase for Resident 10 were missing, his/her room and bathroom was not kept clean, and his/her room was very odorous. POAHC EE described Resident 10's care at the facility as a form of "elder abuse."

On 03/15/2024 at approximately 2:00 PM, Surveyor interviewed Social Worker (SW) HH who had visited Resident 10 a few times and collaborated with occupational and physical

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therapists (OT/PT). SW HH voiced concern of Resident 10 being found in urine or soiled with feces on various visits. S/he presented as though s/he would be laying in bed for longer periods of time and no one had checked on him/her given the odor and state of Resident 10 and his/her room. SW HH indicated Resident 10 had not been showered other than one time when Resident 10's family member requested it. SW HH pushed Resident 10's call light for assistance and waited at least 20 minutes before staff would come to assist. S/he stated s/he was made aware of multiple days where Resident 10 was still not toileted and changed for the day when POAHC EE arrived to the facility late morning. S/he stated s/he was told Resident 10 missed meals because s/he was not assisted up. SW HH voiced concern for Resident 10's care and well-being at the facility.

RESIDENT 12
On 03/14/2024, Surveyor reviewed Resident 12's record and noted s/he was admitted to the facility on 08/09/2019 and had diagnoses of dementia with agitation, major depressive disorder, anxiety disorder, chronic pain syndrome, and MacLeod's syndrome. Resident 12 was unable to fully communicate and verbalize his/her needs. Surveyor reviewed Resident 12's ISP with print date 03/14/2024. Surveyor noted - "BATHING - FULL ASSISTANCE...Resident requires full asstance from staff to complete bathing tasks. Hospice to complete one shower a week and staff to complete one shower a week...Weekly [Wed] at 8:00 AM...
GROOMING - FULL ASSISTANCE...Service Provider Responsibilities: Staff to complet full assistance with grooming tasks...
DRESSING - FULL ASSISTANCE...Service Provider Responsibilities: Staff to complete full

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assistance with dressing needs...
EATING - FULL ASSISTANCE...Service Provider Responsibilities: Staff to help with feeding resident and encourage resident to eat...
ORAL CARE - FULL ASSISTANCE...Full assistance with oral cares. Any usage or [sic] toothbrushes, cleaner, denture removal and cleansing, etc. must be performed by staff...To receive full asstance and to maintain proper oral care.
TOILETING - FULL ASSISTANCE...Resident's Desired Goals & Outcomes: To remain clean & dry. Service Provider Responsibilities: Staff to complet full assistance with toileting needs...
TRANSFERRING - STAFF ASSISTANCE...Provide full assistnace with all transferring needs. Resident does have a fall alarm to promote safety when transferring on own...
HOUSEKEEPING - TOTAL ASSIST...Staff to clean room weekly and prn [as needed]...
LAUNDRY SERVICE...Provide laundry needs. Gather dirty/soiled clothes/linen and wash/dry/fold and put away properly...Weekly [Wed] @ 8:00 AM...
2 HOUR NIGHT TIME CHECKS...Directions: Staff to check on resident every TWO hours at night to ensure safety and brief is dry and clean...
FALL RISK - HIGH...Resident is considered a high fall risk per fall risk assessment...Service Provider Responsibilities:...staff to provide toileting every 4 hours and also to provide one hour checks at night to ensure safety."

On 03/14/2024 at apprxoximately 9:15 AM, Surveyor observed Resident 12 sitting in his/her broda chair in the dining room. Surveyor noted Resident 12 had large sweat pants on that appeared oversized for him/her with bleach stains up and down the front and was wearing a

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mismatched fitted top. Surveyor observed food at the tables for residents, but staff were not assisting Resident 12 with eating.

On 03/14/2024 at approximately 9:20 AM, Surveyor interviewed Hospice Aide GG with Resident 12. Surveyor observed a fall pad alarm and cord on Resident 12's bed that was not connected to a battery pack or box. Hospice Aide GG stated the box that made the fall alarm work had not been connected to the fall pad for months now and noone knew where it went. Surveyor inquired if Resident 12 fell out of bed often and Hospice Aide GG said s/he had in the past. Surveyor noted a fall mat on the floor and a fall pad alarm on Resident 12's broda chair. Hospice Aide GG stated him/her and another hospice aide had been providing morning cares to Resident 12 every day of the week for the past month or more due to the facility not providing the care to Resident 12. S/he said s/he was at the facility 4-5 days a week, and the other aide was there the other days so that Resident 12 was gotten up, cleaned up, and taken to breakfast. Hospice Aide GG stated this was above and beyond what was provided to other hospice patients in facilities. S/he stated Resident 12 received a shower from hospice on Mondays, Wednesdays, and as needed since the facility would not provide a shower to Resident 12 on Wednesdays like listed in his/her care plan. S/he stated Resident 12's hair can get greasy easily, so sometimes s/he needed more showers or at least his/her hair washed. Hospice Aide GG reported the following observations and experiences - Resident 12 was totally soaked with urine upon his/her arrival in the morning, almost every morning or his/her depends would be dry, but his/her chux pad and bed would be soiled with urine; Resident 12 had a dresser full of clothes,

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but majority of them were not his/hers; multiple clothing items of Resident 12's were missing; personal items of Resident 12's such as hair ties, wipes, and soaps had to be hidden in the room so they would not go missing.
Hospice Aide GG reported on 03/01/2024, s/he arrived to the facility to assist Resident 12 up for the day and his/her door was locked. Hospice Aide GG asked staff to open the door and they reported not having a key. Hospice Aide GG indicated the staff reported a resident had locked the door and stole the master key. S/he stated Resident 12 had been in his/her room all night and had not been checked on or changed as Resident 12 could rarely get out of bed, and could not open the door to get out. Once able to get into Resident 12's room, Hospice Aide GG indicated Resident 12 was soaked from head to toe and his/her bed was covered in urine. It was unknown how long Resident 12 was left unchanged and unchecked.

On 03/14/2024 at approximately 10:40 AM, Surveyors interviewed Administrator B who stated "I think hospice comes in [for Resident 12] 1 time per week to do his/her cares and a shower. Administrator B verified awareness of Resident 12 potentially wearing another resident's clothes and other residents' clothes being in Resident 12's room. S/he said "residents are always carrying clothes around; we have to tell them to put the clothes back. It does happen that clothes go missing." Administrator B acknowledged awareness of resident doors being locked and stated the master key was on the medication cart key ring.

On 03/21/2024 at approximately 8:30 AM, Surveyors interviewed Regional Director of Operations Y who acknowledged Resident 10

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Y3244	Continued From page 106 and Resident 12's care needs were not being met. Cross Reference: N0481 Environment Safe, Clean, And Comfortable	Y3244		