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BRIGHTSTAR SENIOR LIVING OF WAUNAKEE	1001 QUINN DR WAUNAKEE, WI 53597

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N 000	Initial Comments On 02/14/2024, with information obtained through 02/28/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation and verification visit at Brightstar Senior Living of Waunakee, a community-based residential facility (CBRF) located in Waunakee, WI. As a result of the survey, 5 deficiencies were identified. The complaint was substantiated. Three of the deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) PI0511, dated 09/27/2023. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 16	N 000		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 2 received prompt and adequate treatment appropriate to his/her needs. At approximately 1:50 a.m. on 01/22/2024, staff	N 353		

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

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documented having found Resident 2 on the floor. Although the provider's staff documented having notified Resident 2's hospice agency at 1:56 a.m., there was no evidence that staff notified Resident 2's hospice agency until 2:14 a.m., approximately 24 minutes after his/her fall and 18 minutes after staff documented having called hospice. The responding hospice registered nurse (RN), Nurse G, attempted to call the facility at 3 different contacts prior to arriving on site but did not receive an answer. When Nurse G arrived to the facility, s/he had to wait approximately 35 minutes to gain entry into the facility. Based on Nurse G's assessment, Resident 2 required further evaluation from an emergency medical provider for further evaluation of his/her right eye injury and corresponding pain.

Findings include:

On 02/14/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 09/19/2022 where s/he resided until 01/22/2024. Resident 2's diagnoses included repeated falls and weakness. Resident 2 was documented as having an activated power of attorney for healthcare (POA). Surveyor reviewed 9 incident reports for Resident 2, which documented 9 falls s/he experienced between 07/01/2023 - 01/22/2024. The most recent incident report, dated 01/22/2024, documented a fall that Resident 2 experienced. The incident report documented the following details:

"Resident pushed call pendant around 150 am. Staff got to residents[sic] room and seen resident facedown[sic] next to [his/her] bed. Staff asked resident what happened and what [s/he] was trying to do and resident stated, 'I don't know, I don't remember.' Resident was asked if [s/he]

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was in any pain, [s/he] denied. Range of motion completed and then resident was rolled over and staff noticed right eye to be swollen and purple in color. Resident stated area was just tender to touch. No other skin concerns noted. Vitals taken, another staff called to assist resident back to bed. Staff called POA, [Manager on Duty (MOD)], RN, and [hospice agency]. [Hospice agency] sending an RN out to assess. [Hospice agency] RN got to community to assess and due to injury decided to send out to [emergency room] for additional evaluation. POA [POA's name] agreed ..."

The incident report documented that staff had notified Resident 2's hospice agency at 1:56 a.m. and that Resident 2 was transported to a nearby emergency department by emergency medical services (EMS) transport "for additional evaluation."

Surveyor observed an observation note entry dated 01/22/2024 at 3:00 p.m., by Caregiver F, which documented the same details about Resident 2's fall that day as above.

On 02/14/2024, at approximately 1:05 p.m., Surveyor interviewed Executive Director A, Director of Health and Wellness C, and Registered Nurse (RN) Case Manager D about Resident 2's fall on 01/22/2024. Director of Health and Wellness C reported that staff called Resident 2's hospice agency after Resident 2's fall because it was routine practice for them to call hospice for further assessment assistance when residents who received hospice services fell after regular business hours.

On 02/19/2024, Surveyor reviewed outside hospice records for Resident 2, obtained from Resident 2's hospice agency. Surveyor observed

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a telephone encounter dated 01/22/2025 at 2:15 a.m., which documented that a phone call from Caregiver F came at 2:14 a.m. due to Resident 2 having fallen. The note documented the following:

- "Is the patient still on the floor? Yes, unable to get patient up, staff to get patient up."
- "Was there an injury? Head trauma? Patient right eye is swollen and bruised."
- "Patient report or signs of pain? Pain to right eye."
- "Is the patient on anticoagulants? Yes aspirin."
- "Is further treatment needed? Nurse to assess."

In the body of the encounter note, Nurse G, the hospice RN who came to the facility to assess Resident 2 after his/her fall, documented: "0250: [Telephone call] to facility, [no answer]. Called main number, [no answer] - unable to get staff on phone. Attempted cell number given by Triage - [no answer]. Updated Triage and gave [estimated time of arrival] of 30 minutes ...Upon arrival to the facility, writer waited at front door for 35 minutes to be let inside. Once inside, [Caregiver F] tells writer patient was found face down on the floor next to [his/her] bed ...Staff noted patient to have significant bruising and swelling to right eye. Patient did not offer [complaint of] pain to anywhere other than right eye. Patient was assisted back to bed with Hoyer lift ...[Vital signs stable], although [blood pressure] a tad hypertensive at 168/80. As patient is on aspirin 81mg daily, writer calls [medical provider] to get recommendation regarding possibly sending patient to [emergency room] for evaluation. [Medical provider] gives okay to do same."

Within the "Fall Documentation" heading of the note, the following was documented:

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- "Was there an injury?: head trauma, significant pain."
- "Treatment: emergent care due to injury."

Surveyor reviewed the emergency department visit note from 01/22/2024, which documented the following:

- Under the "Physical Exam" section: "Right eye with significant periorbital ecchymosis and swelling. Hemorrhagic hyphema present, unable to visualize pupil fully due to swelling ...bruising along arms, scalp."
- Under the "Medical Decision Making" section: " ...goals are just to see if [s/he] has an intracranial hemorrhage or fracture ...[Computed tomography] scans of the head and the facial bones without signs of intracranial hemorrhage or facial bone fractures. [S/he] has a very significant amount of ecchymosis [bruising] and swelling periorbitally over the right eye with a hemorrhagic hyphema [blood collection in the front of the eye]. Did recommend that [s/he] have ophthalmologic examination but they have declined. Do know that this could be vision threatening but do not want to pursue any further evaluation given goals of care which seems reasonable."

On 02/28/2024, at approximately 10:00 a.m., Surveyor interviewed Executive Director A, Director of Health and Wellness C, RN Case Manager D, and Community Director E. Executive Director A reported s/he recalled receiving a phone call from Nurse G during the incident. Executive Director A reported Nurse G had mentioned during the phone call s/he was waiting to be let into the facility. Executive Director A reported s/he then called Caregiver F's personal cell phone to instruct him/her to let Nurse G into the facility. Executive Director A

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N 353	Continued From page 5 reported that Caregiver F may not have had his/her walkie-talkie on him/her, which would have allowed him/her to receive an alert about the doorbell ringing. Executive Director A reported that Caregiver F had stayed by Resident 2's side from the time s/he discovered him/her on the floor to the time Nurse G came to assess Resident 2. Executive Director A reported s/he was not sure why Caregiver F would not have been available to let Nurse G in any earlier but reported that s/he understood Surveyor's concern.	N 353		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the individual service plans (ISPs) for 3 of 4 residents reviewed were reviewed annually or updated when there were changes in the residents' needs, abilities, and physical condition.	N 389		

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N 389	Continued From page 6 This is a repeat deficiency. See Statement of Deficiency (SOD) PI0511, dated 09/27/2023. Resident 1's ISP was not updated to eliminate the information regarding his/her meal consumption tracking. Resident 2's ISP was not updated to include additional interventions to mitigate his/her fall risk. Between 07/01/2023 - 01/22/2023, Resident 2 experienced 15 falls, 6 of which included injuries. Resident 2's fall prevention measures remained unchanged since his/her earliest 2023 ISP review, dated 02/20/2023. Resident 4's ISP has not been reviewed with his/her guardian since 02/21/2022 (almost 2 years prior to the survey). Findings include: Example 1 - Resident 1 On 02/14/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 02/09/2023 with diagnoses including Parkinson's disease and type II diabetes mellitus. Resident 1 was documented as having an activated power of attorney for healthcare (POA). Surveyor reviewed Resident 1's current ISP, last signed as reviewed on 09/29/2023, and observed the following: - Under the "Meal Consumption Monitoring" heading: "Document what [Resident 1] ate at every meal and how much was completed as an observation in ECP." Under the "Snack Monitoring" heading, the following was documented: "Resident requires staff to monitor and document food consumption outside of	N 389		

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scheduled meals."

Surveyor reviewed Resident 1's observation notes from 12/01/2023 - 02/13/2024 and did not observe any documentation regarding the meals s/he consumed on 12/01/2024 through 12/03/2024, 12/06/2024 through 12/09/2024, 12/11/2024 through 12/13/2024, 12/17/2024, 12/21/2024 through 12/25/2024, 12/27/2024, 12/30/2024 through 01/02/2024, 01/04/2024, 01/06/2024, 01/07/2024, 01/09/2024, 01/10/2024, 01/13/2024, 01/17/2024, 01/18/2024, 01/20/2024, 01/21/2024, 01/23/2024, 01/24/2024, 01/26/2024 through 01/28/2024, 01/30/2024 through 02/02/2024, 02/04/2024 through 02/10/2024, 02/12/2024, 02/13/2024.

At approximately 2:11 p.m., Surveyor requested from Executive Director A, Director of Health and Wellness C, and Registered Nurse (RN) Case Manager D all records with Resident 1's meal consumption tracking. Director of Health and Wellness C reported that staff don't typically document meals consumed for residents since the facility was not a skilled nursing facility. When asked about the meal tracking information in Resident 1's ISP, Director of Health and Wellness C reported s/he didn't think meals for Resident 1 needed to be tracked and wasn't sure why this was in his/her ISP. Executive Director A reported s/he wasn't sure why meal tracking was in Resident 1's ISP. Executive Director A reported s/he was unsure if there was a previous time that Resident 1 required his/her meal consumption to be tracked.

Example 2 - Resident 2

On 02/14/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider

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on 09/19/2022 where s/he resided until 01/22/2024. Resident 2's diagnoses included repeated falls and weakness. Resident 2 was documented as having an activated POA. Surveyor reviewed 9 incident reports for Resident 2, which documented 9 falls s/he experienced between 07/01/2023 - 01/22/2024 and included the following information:

- 08/03/2023 (9:30 a.m.): "Resident attempted to stand up from the toilet independently and fell, falling in-between[sic] the sink and the toilet."

- 08/07/2023 (5:54 a.m.): "Resident Assistant responded to a call light for [Resident 2]. When they arrived [Resident 2] was sitting on the floor next to [his/her] chair. [Resident 2] had stated [s/he] was trying to sit in [his/her] recliner, missed and landed on [his/her] buttocks on the floor ..."

- 10/12/2023 (7:45 a.m.): "Resident assistant went to [Resident 2]'s apartment at 745am to escort [him/her] to the dining room for breakfast. When they entered [his/her] apartment, [Resident 2] was found sitting on the floor in front of [his/her] chair. [Resident 2] stated that [s/he] slid off [his/her] chair onto the floor ...The RA noticed that [Resident 2] had a bruise on [his/her] right eye, right arm. [Resident 2] couldn't recall how they may have gotten there ..."

- 11/16/2023 (1:20 a.m.): " ...Upon entering the apt. Resident was found on floor near [his/her] recliner. RA asked resident if they [s/he][sic] was okay and noticed a skin tear on right forearm ..."

- 11/19/2023 (4:30 a.m.): "Resident attempted to get out of bed [without] requesting assistance to go to the bathroom. [S/he] pressed pendant and called for help after [s/he] fell."

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N 389	Continued From page 9 - 12/01/2023 (4:33 a.m.): "Resident attempted to get out of bed without calling for help and after resident fell on the floor face down next to [his/her] bed is when [s/he] used [his/her] pendant to call for help ..." - 12/05/2023 (7:00 a.m.): "Med passer ...walked into resident bathroom to find [him/her] sitting on [his/her] buttocks on the floor with [his/her] walker by [him/her] ..." - 12/26/2023 (9:10 a.m.): "Per [hospice agency] RN who came out to see resident today, that resident told [him/her] [s/he] had a fall earlier this morning. Per care staff, noted a bruise on [his/her] right arm, right hand and right knee with a rug burn noted. Resident ...thought s/he fell out of bed this morning ..." - 01/22/2024 (2:17 a.m.): " ...Staff got to residents[sic] room and seen resident facedown[sic] next to [his/her] bed. Staff asked resident what happened and what [s/he] was trying to do and resident stated, 'I don't know, I don't remember.' Resident ...was rolled over and staff noticed right eye to be swollen and purple in color. Resident stated area was just tender to touch ...[Hospice agency] RN got to community to assess and due to injury decided to send out to [emergency room] for additional evaluation ..." Surveyor reviewed Resident 2's observation notes from 07/01/2023 - 01/22/2024 and observed 1 additional fall documented at 7:45 a.m. on 10/13/2023 with the annotation, "Resident had fall at 6:07am ..." Surveyor reviewed Resident 2's ISPs for 2023. One was dated as reviewed on 02/20/2023 and	N 389		

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the most recent one prior to his/her discharge was dated as reviewed on 10/06/2023. In both ISPs, Resident 2 was documented as requiring the assistance of 1 staff for all transfers. In the ISP dated 02/30/2023, Surveyor observed the following regarding Resident 2's fall risk:

- Under the "Risk - Fall" heading: "Visual check on resident to assure safety. Prompt toileting at 10pm every night ...[Resident 2] has been identified as a fall risk. [S/he] has a history of frequent falls, stroke, and increased weakness since [his/her] most recent hospital admission (11/10/22)." Service provider responsibilities were documented as "Nonslip footwear when out of bed. Use of safe transfer equipment when sitting, standing, or ambulating. Ensure areas are free of clutter or fall hazards. Promote healthy sleep-wake cycle. Encourage use of call pendant, particularly at nighttime for toileting assistance (recent falls around this time for this purpose)."

In Resident 2's most recent ISP, dated 10/06/2023, the same information under the "Risk-Fall" heading was documented as in his/her 02/20/2023 ISP. Surveyor did not observe any additional information about Resident 2's fall risk or other interventions initiated by the provider to mitigate Resident 2's fall risk. Surveyor observed that from 07/01/2023 - 10/06/2023 (when Resident 2's ISP was last updated), Resident 2 was documented as having 2 falls. Surveyor observed that Resident 2 was documented as having 8 falls after his/her last ISP review on 10/06/2023.

At approximately 1:50 p.m., Surveyor interviewed Executive Director A, Director of Health and Wellness C, RN Case Manager D, and Community Director E regarding Resident 2's fall

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risk interventions. Director of Health and Wellness C and RN Case Manager D denied having implemented any other fall interventions for Resident 2. Executive Director A reported that the interventions used by staff to mitigate Resident 2's fall risk included having staff remind him/her to use his/her pendant, assist Resident 2 to go to the bathroom, and having staff check on Resident 2 every 2 hours. After reviewing Resident 2's ISPs with Executive Director A, s/he confirmed that these interventions were already listed as general interventions and that no other interventions were used.

On 02/23/2024, Surveyor reviewed outside hospice records obtained for Resident 2. Surveyor observed evidence of 5 additional falls documented, which were not documented in the provider's record for Resident 2. These falls included:

- 09/20/2023: Nurse (RN) visit note, within the skin assessment section, documented, " ...patient had a fall this morning, yellow colored bruise noted to right hip. Full [range of motion] noted, no pain or discomfort upon palpation ..."

- 10/11/2023: Certified nursing assistant (CNA) visit note documented, " ...[Patient] was a little shaken this visit. [Patient] stated having fallen out of [his/her] bed prior to visit. [Patient] declined injury or pain, but stated feeling jittery ..." The visit time was documented as 6:00 p.m. - 6:40 p.m. (See below annotation, where a fall on 10/11/2023 is also discussed.)

- 10/12/2023: RN visit note documented, " ...Facility caregiver came into patient's room. [S/he] reported that [s/he]'s been checking on patient frequently throughout the morning. [S/he]

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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 389	Continued From page 12	N 389		

states that patient was found sitting on floor next to [his/her] recliner. [S/he] states that patient seemed a little unsteady on [his/her] feet this morning after the fall, but states [s/he] has been putting patient's walker in [his/her] room away from patient so patient remembers to call for help. Writer collaborated with facility director [Executive Director A]. [Executive Director A] reports that patient had slipped out of [his/her] recliner on PM shift last night, slipped out of recliner on [overnight (NOC)] shift, and also this morning ..." Surveyor observed that only one of the falls that occurred between 10/11/2023 - 10/12/2023 (the fall on the morning of 10/12/2023) was documented in the provider's record for Resident 2. Both falls on 10/11/2023 were not documented.

- 10/18/2023: RN visit note documented, "Right occipital bruise and bilateral forearm bruising noted from a fall on Saturday according to facility staff ...Fall prevention measures discussed with [Caregiver H]. [Caregiver H] verbalized understanding." Surveyor observed that the provider's record for Resident 2 did not have any information of a fall that occurred that Saturday (10/14/2023).

- 12/06/2023: Telephone call note documented that [Caregiver I] called at 8:04 a.m. due to Resident 2 having a fall at approximately 7:00 a.m. that morning. The note documented, "[Caregiver I] reports that [patient] is supposed to use pendant for assistance, but will often self-transfer with walker ..." The RN visit note that same day documented, " ...[Resident 2] reports [s/he] 'slid off' the toilet this morning ...Collaboration during this visit: [RN Case Manager D]."

Also within Resident 2's hospice notes, Surveyor

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N 389	Continued From page 13 observed an encounter note dated 08/05/2023 which documented that Resident 2 was having "increased falls, falling at least every 2 weeks," and an RN visit note dated 12/29/2023 that documented, "[Resident 2] has been more confused the last few months. [Patient] continues to try to get up with out[sic] help and ends up falling. Multiple bruises and skin tears as a result of falls. [Patient] weaker the last few months ..." Example 3 - Resident 4 On 02/14/2024, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 10/01/2019 with diagnoses including history of pulmonary embolism and essential hypertension. Resident 4 was documented as having a guardian. Surveyor reviewed Resident 4's current ISP, last signed as reviewed on 02/21/2022 (almost 2 years prior to the survey). At approximately 2:30 p.m., Surveyor interviewed Executive Director A, Director of Health and Wellness C, and RN Case Manager D regarding Resident 4's ISP. Director of Health and Wellness C confirmed s/he did not have a more current care plan than the one reviewed by Surveyor. Executive Director A reported that the provider has had changeover in directors and staff and that they are working on getting ISPs updated. RN Case Manager D reported that s/he e-mailed Resident 4's ISP to his/her guardian last week for review and signature. When asked what date the e-mail was sent, RN Case Manager D clarified that when s/he looked in his/her e-mail records, s/he did not see that the e-mail ever sent.	N 389		
N 415	83.37(2)(d) Documentation of medication administration.	N 415		

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N 415	Continued From page 14 Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that at the time of medication administration the person administering the medication initialed the medication administration record (MAR) and documented the need for and response to as needed (PRN) medication for 3 of 3 residents. The MAR for Resident 1 contained 48 missing entries across 13 days from 01/01/2024 - 02/13/2024. The MAR for Resident 4 contained 63 missing entries across 15 days from 01/01/2024 - 02/13/2024. The MAR for Resident 5 contained 90 missing entries across 12 days from 01/01/2024 - 02/13/2024. For 4 entries of PRN medication administered to Resident 5, staff did not document the need for the medication, the response to the medication, or both.	N 415		

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N 415	Continued From page 15 This is a repeat deficiency. See Statement of Deficiency (SOD) PI0511, dated 09/27/2023. Findings include: Example 1 - Resident 1 On 02/14/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 02/09/2023 with diagnoses including Parkinson's disease and type II diabetes mellitus. Surveyor reviewed Resident 1's MAR from 01/01/2024 - 02/13/2024 and observed the following 48 blank entries across 13 days: - 01/02/2024: Acetaminophen 325 mg tablets (6:00 a.m.) - 01/06/2024: Carbidopa/Levodopa 25-100 mg tablets (12:00 p.m.), Loperamide 2 mg capsule (12:00 p.m.) - 01/12/2024: Carbidopa/Levodopa 25-100 mg tablets (8:00 p.m.), Loperamide 2 mg capsule (8:00 p.m.) - 01/18/2024: Carbidopa/Levodopa 25-100 mg tablets (12:00 p.m.), Loperamide 2 mg capsule (12:00 p.m.), Acetaminophen 325 mg tablets (12:00 p.m.) - 01/21/2024: Lantus SoloStar 100 unit/mL pen 10 units (8:00 a.m.) - 01/27/2024: Carbidopa/Levodopa 25-100 mg tablets (8:00 p.m.), Loperamide 2 mg capsule (8:00 p.m.) - 01/28/2024: Carbidopa/Levodopa 25-100 mg tablets (8:00 p.m.), Loperamide 2 mg capsule (8:00 p.m.), Acetaminophen 325 mg tablets (6:00 p.m.) - 01/30/2024: Carbidopa/Levodopa 25-100 mg tablets (12:00 p.m.), Loperamide 2 mg capsule (12:00 p.m.), Acetaminophen 325 mg tablets (12:00 p.m.)	N 415		

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N 415	Continued From page 16 - 02/04/2024: Carbidopa/Levodopa 25-100 mg tablets (8:00 a.m.), Gabapentin 300 mg capsule (8:00 a.m.), Vitamin B-6 100 mg tablet (8:00 a.m.), Vitamin D-3 10 mcg tablet (8:00 a.m.), Loperamide 2 mg capsule (8:00 a.m.), Acetaminophen 325 mg tablets (6:00 a.m.), Lantus SoloStar 100 unit/mL pen 10 units (8:00 a.m.) - 02/06/2024: Carbidopa/Levodopa 25-100 mg tablets (12:00 p.m. and 8:00 p.m.), Loperamide 2 mg capsule (12:00 p.m. and 8:00 p.m.), Acetaminophen 325 tablets (12:00 p.m. and 6:00 p.m.) - 02/07/2024: Carbidopa/Levodopa 25-100 mg tablets (5:00 p.m. and 8:00 p.m.), Loperamide 2 mg capsule (4:00 p.m. and 8:00 p.m.), Acetaminophen 325 mg tablets (6:00 p.m.) - 02/08/2024: Carbidopa/Levodopa 25-100 mg tablets (12:00 p.m., 5:00 p.m., and 8:00 p.m.), Loperamide 2 mg capsule (12:00 p.m., 4:00 p.m., and 8:00 p.m.), Acetaminophen 325 tablets (12:00 p.m. and 6:00 p.m.) - 02/12/2024: Carbidopa/Levodopa 25-100 mg tablets (5:00 p.m. and 8:00 p.m.), Loperamide 2 mg capsule (4:00 p.m. and 8:00 p.m.), Acetaminophen 325 mg tablets (6:00 p.m.) Example 2 - Resident 4 On 02/14/2024, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 10/01/2019 with diagnoses including history of pulmonary embolism and essential hypertension. Surveyor reviewed Resident 4's MAR from 01/01/2024 - 02/13/2024 and observed the following 63 blank entries across 15 days: - 01/04/2024: Nystatin powder (12:00 p.m. and 8:00 p.m.) - 01/07/2024: Acetaminophen 500 mg tablets	N 415		

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(2:00 p.m.), Nystatin powder (12:00 p.m.)
- 01/12/2024: Acetaminophen 500 mg tablets (2:00 p.m. and 8:00 p.m.), Eliquis 5 mg tablet (8:00 p.m.), Metoprolol tartrate 25 mg tablet (8:00 p.m.), Nystatin powder (8:00 p.m.), Rosuvastatin 20 mg tablet (8:00 p.m.), Levetiracetam 750 mg tablet (8:00 p.m.)
- 01/13/2024: Acetaminophen 500 mg tablets (2:00 p.m.)
- 01/23/2024: Acetaminophen 500 mg tablets (2:00 p.m. and 8:00 p.m.)
- 01/25/2024: Nystatin powder (12:00 p.m.)
- 01/26/2024: Acetaminophen 500 mg tablets (8:00 a.m.), Nystatin powder (12:00 p.m.)
- 01/28/2024: Acetaminophen 500 mg tablets (8:00 p.m.), Eliquis 5 mg tablet (8:00 p.m.), Metoprolol tartrate 25 mg tablet (8:00 p.m.), Nystatin powder (12:00 p.m. and 8:00 p.m.), Rosuvastatin 20 mg tablet (8:00 p.m.), Levetiracetam 750 mg tablet (8:00 p.m.)
- 01/30/2024: Nystatin powder (12:00 p.m.)
- 02/01/2024: Acetaminophen 500 mg tablets (8:00 p.m.),
- 02/04/2024: Acetaminophen 500 mg tablets (8:00 a.m.), Eliquis 5 mg tablet (8:00 a.m.), Metoprolol tartrate 25 mg tablet (8:00 a.m.), Nystatin powder (8:00 a.m.), Omeprazole 20 mg capsule (8:00 a.m.), Sertraline 25 mg tablet (8:00 a.m.), Calcium 600 + Vitamin D 200 tablet (8:00 a.m.), Senna-Docusate 8.6-50 mg tablet (8:00 a.m.), Levetiracetam 750 mg tablet (8:00 a.m.)
- 02/06/2024: Acetaminophen 500 mg tablets (8:00 a.m. and 8:00 p.m.), Eliquis 5 mg tablet (8:00 p.m.), Metoprolol tartrate 25 mg tablet (8:00 p.m.), Nystatin powder (8:00 p.m.), Calcium 600 + Vitamin D 200 tablet (8:00 a.m.), Rosuvastatin 20 mg tablet (8:00 p.m.), Levetiracetam 750 mg tablet (8:00 p.m.)
- 02/07/2024: Acetaminophen 500 mg tablets (8:00 p.m.), Eliquis 5 mg tablet (8:00 p.m.),

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Metoprolol tartrate 25 mg tablet (8:00 p.m.), Nystatin powder (8:00 p.m.), Rosuvastatin 20 mg tablet (8:00 p.m.), Levetiracetam 750 mg tablet (8:00 p.m.)
- 02/08/2024: Acetaminophen 500 mg tablets (2:00 p.m. and 8:00 p.m.), Eliquis 5 mg tablet (8:00 p.m.), Metoprolol tartrate 25 mg tablet (8:00 p.m.), Nystatin powder (12:00 p.m. and 8:00 p.m.), Rosuvastatin 20 mg tablet (8:00 p.m.), Levetiracetam 750 mg tablet (8:00 p.m.)
- 02/12/2024: Acetaminophen 500 mg tablets (8:00 p.m.), Eliquis 5 mg tablet (8:00 p.m.), Metoprolol tartrate 25 mg tablet (8:00 p.m.), Nystatin powder (8:00 p.m.), Rosuvastatin 20 mg tablet (8:00 p.m.), Levetiracetam 750 mg tablet (8:00 p.m.)

Example 3 - Resident 5

On 02/14/2024, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider on 02/30/2023 with diagnoses including major depressive disorder, panic disorder, and anxiety disorder. Surveyor reviewed Resident 5's MAR from 01/01/2024 - 02/13/2024 and observed the following 90 blank entries across 12 days:

- 01/10/2024: Simvastatin 40 mg tablet (5:00 p.m.), Lorazepam 0.5 mg tablet (8:00 p.m.)
- 01/12/2024: Aspirin 81 mg tablet (8:00 a.m.), Lorazepam 0.5 mg tablet (8:00 p.m.)
- 01/13/2024: Gabapentin 100 mg capsules (8:00 p.m.), Haloperidol 2 mg tablet (8:00 p.m.), Lamotrigine 100 mg tablets (8:00 p.m.), Mirtazapine 7.5 mg tablet (8:00 p.m.), Olanzapine 10 mg tablets (8:00 p.m.), Simvastatin 40 mg tablet (5:00 p.m.), Trazodone 100 mg tablet (8:00 p.m.), Melatonin 3 mg tablet (8:00 p.m.), Lorazepam 0.5 mg tablet (8:00 p.m.)
- 01/18/2024: Lorazepam 0.5 mg tablet (8:00

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N 415	Continued From page 19 p.m.) - 01/28/2024: Gabapentin 100 mg capsules (8:00 p.m.), Haloperidol 2 mg tablet (8:00 p.m.), Lamotrigine 100 mg tablets (8:00 p.m.), Mirtazapine 7.5 mg tablet (8:00 p.m.), Olanzapine 10 mg tablets (8:00 p.m.), Simvastatin 40 mg tablet (5:00 p.m.), Trazodone 100 mg tablet (8:00 p.m.), Melatonin 3 mg tablet (8:00 p.m.), Lorazepam 0.5 mg tablet (8:00 p.m.) - 02/02/2024: Gabapentin 100 mg capsules (8:00 p.m.), Haloperidol 2 mg tablet (8:00 p.m.), Lamotrigine 100 mg tablets (8:00 p.m.), Mirtazapine 7.5 mg tablet (8:00 p.m.), Olanzapine 10 mg tablets (8:00 p.m.), Trazodone 100 mg tablets (8:00 p.m.), Melatonin 2 mg tablet (8:00 p.m.), Lorazepam 0.5 mg tablet (8:00 p.m.) - 02/03/2024: Fluticasone 50 mcg nasal spray (8:00 a.m.), Folic acid 400 mcg tablet (8:00 a.m.), Gabapentin 100 mg capsule (2:00 p.m.), Haloperidol 2 mg tablet (8:00 a.m.), Lamotrigine 100 mg tablets (8:00 a.m.), Olanzapine 5 mg tablet (8:00 a.m.), Omeprazole 20 mg capsule (8:00 a.m.), Sertraline 100 mg tablets (8:00 a.m.), Aspirin 81 mg tablet (8:00 a.m.), Lorazepam 0.5 mg tablet (8:00 a.m.) - 02/04/2024: Fluticasone 50 mcg nasal spray (8:00 a.m.), Folic acid 400 mcg tablet (8:00 a.m.), Gabapentin 100 mg capsule (2:00 p.m.), Haloperidol 2 mg tablet (8:00 a.m.), Lamotrigine 100 mg tablets (8:00 a.m.), Olanzapine 5 mg tablet (8:00 a.m.), Omeprazole 20 mg capsule (8:00 a.m.), Sertraline 100 mg tablets (8:00 a.m.), Aspirin 81 mg tablet (8:00 a.m.), Lorazepam 0.5 mg tablet (8:00 a.m.) - 02/06/2024: Gabapentin 100 mg capsules (2:00 p.m. and 8:00 p.m.), Haloperidol 2 mg tablet (8:00 p.m.), Lamotrigine 100 mg tablets (8:00 p.m.), Mirtazapine 7.5 mg tablet (8:00 p.m.), Olanzapine 10 mg tablets (8:00 p.m.), Simvastatin 40 mg tablet (5:00 p.m.), Trazodone	N 415		

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100 mg tablets (8:00 p.m.), Melatonin 2 mg tablet (8:00 p.m.), Lorazepam 0.5 mg tablet (8:00 p.m.)
- 02/07/2024: Gabapentin 100 mg capsules (8:00 p.m.), Haloperidol 2 mg tablet (8:00 p.m.), Lamotrigine 100 mg tablets (8:00 p.m.), Mirtazapine 7.5 mg tablet (8:00 p.m.), Olanzapine 10 mg tablets (8:00 p.m.), Simvastatin 40 mg tablet (5:00 p.m.), Trazodone 100 mg tablets (8:00 p.m.), Melatonin 2 mg tablet (8:00 p.m.), Lorazepam 0.5 mg tablet (8:00 p.m.)
- 02/08/2024: Gabapentin 100 mg capsules (2:00 p.m. and 8:00 p.m.), Haloperidol 2 mg tablet (8:00 p.m.), Lamotrigine 100 mg tablets (8:00 p.m.), Mirtazapine 7.5 mg tablet (8:00 p.m.), Olanzapine 10 mg tablets (8:00 p.m.), Simvastatin 40 mg tablet (5:00 p.m.), Trazodone 100 mg tablets (8:00 p.m.), Melatonin 2 mg tablet (8:00 p.m.), Lorazepam 0.5 mg tablet (8:00 p.m.)
- 02/13/2024: Fluticasone 50 mcg nasal spray (8:00 a.m.), Folic acid 400 mcg tablet (8:00 a.m.), Gabapentin 100 mg capsule (8:00 a.m.), Haloperidol 2 mg tablet (8:00 a.m.), Lamotrigine 100 mg tablets (8:00 a.m.), Olanzapine 5 mg tablet (8:00 a.m.), Omeprazole 20 mg capsule (8:00 a.m.), Sertraline 100 mg tablets (8:00 a.m.), Aspirin 81 mg tablet (8:00 a.m.), Lorazepam 0.5 mg tablet (8:00 a.m.)

Surveyor reviewed Resident 5's PRN medication, which included the following:

- Lorazepam 1 mg tablet with instructions to, "Take 1/2 tablet (0.5 mg) by mouth once daily as needed for anxiety."
- Acetaminophen 325 mg tablets with instructions to, "Take 2 tablets (650 mg) by mouth every 4 hours as needed for fever or pain ..."

Within the same date range as above, Surveyor also observed the following missing information

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N 415	Continued From page 21 across 4 entries with regards to PRN medication administered to Resident 5: - 01/12/2024 (2:05 p.m.): PRN Lorazepam 0.5 mg tablet administered for "Anxiety" - no response documented - 01/14/2024 (12:25 p.m.): 2 PRN Acetaminophen 325 mg tablets administered - no reason documented - 01/16/2024 (11:39 a.m.): 2 PRN Acetaminophen 325 mg tablets administered - no reason or response documented - 01/19/2024 (6:57 a.m.): PRN Lorazepam 0.5 mg tablet administered - no response documented INTERVIEW: On 02/14/2024, at approximately 2:35 p.m., Surveyor interviewed Executive Director A, Director of Health and Wellness C, and Registered Nurse (RN) Case Manager D. When asked if they were aware of any issues of staff documenting in resident MARs, Director of Health and Wellness C reported that s/he noticed the missing entries in the MARs for Residents 1, 4, and 5 when s/he was printing them off. RN Case Manager D reported that s/he planned to audit MARs and further discuss the concern of missing entries with staff.	N 415		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health	N 431		

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monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that the health of Residents 1, 2, and 4 was monitored.

There was no evidence of staff checking Resident 1's blood sugar on 44 occasions from 01/01/2023 - 02/13/2023. Within Resident 1's insulin prescription instructions as well as his/her current ISP, staff were directed to notify the provider's Director of Health and Wellness and the manager as well as his/her medical provider

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when his/her blood sugars were <70. Of 3 occasions, from 01/01/2023 - 02/13/2024, in which Resident 1's blood sugars were <70, there was no evidence that the appropriate parties were notified of these occurrences, that staff administered Resident 1's prescribed glucose chew tablets, or that staff re-checked his/her blood sugar to determine if further administration of the chew tablets were needed. Staff held Resident 1's insulin on 7 occasions from 01/01/2024 - 02/13/2024 without an order from his/her medical provider or under the direction of a clinician.

From 09/20/2023 - 01/18/2024, Resident 2 experienced 14 total falls, 5 of which were only discovered from Resident 2's outside hospice records and evidence of which were not documented in Resident 2's record. Within this same date range, Resident 2's hospice records documented Resident 2 having various skin injuries, including scratches, bruises, and skin tears observed at his/her lower extremities, upper extremities, head, and back - several of which were not documented in the provider's record for Resident 2 despite Resident 2 requiring assistance of staff for cares. When skin injuries were documented by the provider's staff, the extent of the injuries were not documented and there was no evidence of any follow up monitoring of them by staff. The provider conducted an investigation of Resident 2's bruising when concerns were raised by his/her hospice agency on 01/18/2024. The provider's investigation did not identify the extent of bruising that the independent hospice investigation identified, and there was no follow up information obtained when 2 staff, Caregivers K and J, confirmed they had observed "spots" and bruising on Resident 2.

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N 431	Continued From page 24 From 01/18/2023 - 02/13/2023, there was no evidence that staff checked Resident 4's blood pressure on 15 occasions. Resident 4 was prescribed a blood pressure medication that had hold parameters dependent on his/her systolic blood pressure. Findings include: Example 1 - Resident 1 On 02/14/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 02/09/2023 with diagnoses including Parkinson's disease and type II diabetes mellitus. Resident 1 was documented as having an activated power of attorney for healthcare (POA). Resident 1's current individual service plan (ISP), last signed as reviewed on 09/23/2023, documented that Resident 1's blood glucose was to be checked 3x/day with the blood glucose value recorded in the provider's electronic record system. The times for checks were documented as 7:00 a.m., 11:00 a.m., and 8:00 p.m. An annotation also documented, "**MUST notify [Director of Health and Wellness] ...if below 70 or above 400.**" Surveyor reviewed an order within Resident 2's medical provider orders for Accu-Chek guide test strips with instructions to, "Use as directed to test 3 times daily." Resident 2 was prescribed a Lantus SoloStar 100 unit/mL insulin pen, and within the order a note was added to, "Call [primary care provider] with blood sugar greater than 500 or less than 70, only call during regular business hours." Surveyor reviewed Resident 1's medication administration records (MARs), vitals history records, and observation notes from 01/01/2023 - 02/13/2023 - within all which staff appeared to document	N 431		

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N 431	Continued From page 25 Resident 1's blood sugar levels. Resident 1's MARs documented blood sugar checks occurring at 8:00 a.m., 12:00 p.m., and 8:00 p.m. Surveyor did not observe blood sugar values recorded for the following 44 dates and approximate times they would have been due in accordance with his/her ISP: - 01/01/2024: 12:00 p.m. and 8:00 p.m. - 01/03/2024: 12:00 p.m. and 8:00 p.m. - 01/05/2024: 8:00 p.m. - 01/06/2024: 8:00 a.m. and 8:00 p.m. - 01/07/2024: 12:00 p.m. - 01/08/2024: 8:00 p.m. - 01/09/2024: 8:00 p.m. - 01/10/2024: 8:00 p.m. - 01/11/2024: 8:00 a.m. and 12:00 p.m. - 01/14/2024: 8:00 p.m. - 01/15/2024: 8:00 p.m. - 01/17/2024: 8:00 p.m. - 01/18/2024: 12:00 p.m. and 8:00 p.m. - 01/20/2024: 12:00 p.m. and 8:00 p.m. - 01/21/2024: 8:00 a.m., 12:00 p.m., and 8:00 p.m. - 01/23/2024: 12:00 p.m. - 01/25/2024: 12:00 p.m. - 01/26/2024: 12:00 p.m. and 8:00 p.m. - 01/27/2024: 8:00 p.m. - 01/28/2024: 12:00 p.m. and 8:00 p.m. - 01/30/2024: 12:00 p.m. - 01/31/2024: 8:00 p.m. - 02/01/2024: 8:00 p.m. - 02/02/2024: 8:00 p.m. - 02/03/2024: 8:00 p.m. - 02/04/2024: 8:00 a.m. and 12:00 p.m. - 02/07/2024: 8:00 p.m. - 02/08/2024: 12:00 p.m. and 8:00 p.m. - 02/09/2024: 8:00 a.m. and 12:00 p.m. - 02/12/2024: 8:00 p.m. - 02/13/2024: 12:00 p.m.	N 431		

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N 431	Continued From page 26 Within the dates/times staff recorded Resident 1's blood sugar values, Surveyor observed the following 3 occasions in which Resident 1's blood sugar was documented as less than 70: - 01/23/2024 (7:33 a.m.): Blood sugar documented as 53 (On the corresponding MAR entry staff documented holding Resident 1's Lantus due to his/her vitals) - 01/25/2024 (7:19 a.m.): Blood sugar documented as 51 (On the corresponding MAR entry staff documented holding Resident 1's Lantus due to his/her vitals) - 02/08/2024 (7:22 a.m.): Blood sugar documented as 65 (On the corresponding MAR entry staff documented holding Resident 1's Lantus due to his/her vitals) Surveyor observed that Resident 1 was prescribed a glucose 4 gm chew with instructions to, "Take 4 tablets by mouth as needed may repeat in 15 minutes if blood glucose is still below 70 mg/dL." For the above 3 dates/times, Surveyor did not observe any evidence in Resident 1's record indicating that staff made Resident 1's primary care provider, as directed from his/her order note, or other facility staff, as directed in his/her ISP, aware of the blood sugars being under 70. Surveyor did not observe any documented evidence of any other follow up action taken by staff, including administering his/her glucose chew or re-checking his/her blood sugar. While reviewing Resident 1's MARs, Surveyor observed the following 7 occasions that staff documented holding Resident 1's insulin specifically due to "No pass per vitals," or documented administering Resident 1 0 units of	N 431		

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N 431	Continued From page 27 insulin: - 01/04/2024 (7:22 a.m.): Blood sugar documented as 106, held due to, "No pass per vitals" - 01/18/2024 (7:26 a.m.): Blood sugar documented as 99, 0 units documented as administered - 01/20/2024 (7:17 a.m.): Blood sugar documented as 70, held due to, "No pass per vitals" - 01/27/2024 (7:55 a.m.): Blood sugar documented as 90, 0 units documented as administered - 01/30/2024 (9:32 a.m.): Blood sugar documented as 108, 0 units documented as administered - 02/02/2024 (6:58 a.m.): Blood sugar documented as 107, 0 units documented as administered - 02/05/2024 (7:07 a.m.): Blood sugar documented as 108, 0 units documented as administered While cross-referencing the above dates/times with Resident 1's observation notes, Surveyor observed only 1 entry that discussed the holding of Resident 1's insulin. This entry, dated 02/05/2024 at 8:30 a.m., documented, "Resident [blood sugars] were a little lower this morning no insulin given this morning." Surveyor did not observe a specific hold parameter noted in Resident 1's insulin order or any evidence in Resident 1's record that his/her insulin was withheld for the above dates/times under the instruction of a medical provider or registered nurse. On 02/14/2024, at approximately 2:35 p.m.,	N 431		

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N 431	Continued From page 28 Surveyor interviewed Executive Director A, Director of Health and Wellness C, and Registered Nurse (RN) Case Manager D. Director of Health and Wellness C confirmed that Resident 1's blood sugars were to be checked 3 times daily. All 3 denied awareness of any issues surrounding his/her blood sugar testing or that his/her blood sugars were not being consistently tested 3 times daily. On 02/28/2024, at approximately 10:00 a.m., Surveyor interviewed Executive Director A, Director of Health and Wellness C, RN Case Manager D, and Community Director E. Both Director of Health and Wellness C and RN Case Manager D confirmed that staff are expected to administer Resident 1 his/her glucose tablets and recheck his/her blood sugar when s/he has blood sugar readings less than 70. Executive Director A reported s/he thought staff were following up and reporting low blood sugars because s/he recalled receiving past phone calls when Resident 1 had low blood sugars. S/he reported that during these phone calls, staff had reported following up with giving Resident 1 glucose tablets or orange juice. Executive Director A acknowledged Surveyor's concern that there was no evidence of follow up monitoring by, notification from, or actions taken by staff (such as tablet administration) since there was no documentation of it. Regarding the holding of Resident 1's insulin, Director of Health and Wellness C reported that staff would only be expected to hold insulin after calling him/her or the manager to report a blood sugar value under 70 and being instructed by him/her or the manager to hold it. Executive Director A reported that management staff would follow up with Resident 1's medical provider for hold parameter guidance.	N 431		

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N 431	Continued From page 29 Example 2 - Resident 2 On 02/14/2024, Surveyor conducted a complaint investigation into allegations of inconsistent injury monitoring of residents. On 02/14/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 09/19/2022 where s/he resided until 01/22/2024. Resident 2's diagnoses included repeated falls and weakness. Resident 2 was documented as having an activated POA. Surveyor reviewed incident/fall reports for Resident 2, from 07/01/2023 - 01/22/2024, which documented the following injuries s/he sustained after falls: - 10/12/2023 (7:45 a.m.): " ...The [resident assistant (RA)] noticed that [Resident 2] had a bruise on [his/her] right eye, right arm. [Resident 2] couldn't recall how they may have gotten there. RA checked for further injuries. None were noted ..." A body chart with the report indicated a bruise at Resident 2's right eye and right anterior forearm. No other information about the bruising was documented. - 11/16/2023 (1:20 a.m.): " ...RA ...noticed a skin tear on right forearm ..." A body chart with the report indicated a skin tear at Resident 2's right anterior forearm. No other information about the skin tear was documented. - 12/26/2023 (9:10 a.m.): "Per care staff, noted a bruise on [his/her] right arm, right hand and right knee with a rug burn noted ..." A body chart with the report indicated a bruise at Resident 2's right dorsal wrist area and a scrape/abrasion at his/her right anterior knee.	N 431		

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Surveyor reviewed Resident 2's observation notes, from 07/01/2023 - 01/22/2024, which documented the following additional injuries sustained by Resident 2:

- 10/11/2023 (8:30 a.m., by Caregiver I): "Resident has large purple bruising on rightside[sic] of neck, RA [Caregiver H] let Lead[sic] know, lead informed [Executive Director A]. There was no other information in Resident 2's record about this bruising, including information about a potential source/cause.

- 12/28/2023 (4:15 p.m., by Caregiver J): "[Resident 2] also has a scratch on [his/her] left leg from a few days ago when I reported to the [hospice agency] nurse concerning [his/her] left arm." There was no other information in Resident 2's record about a left leg scratch or left arm concern. The closest incident, from the above incident report on 12/26/2023, documented that Resident 2 had sustained a bruising and rugburn on his/her right arm/hand and right knee. There was no information in this report or in the observation notes about left upper or lower extremity concerns.

- 01/18/2024 (2:30 p.m., by Executive Director A): "I received a call today from a [hospice agency] manager stating that a nurse was out to see [Resident 2] and noticed a bruise on top of [his/her] left forearm near [his/her] wrist. Considered a bruise of unknown origin; however, BrightStar and [hospice agency] are going to do an investigation with their staff to see if, when or what happened with [Resident 2] that may have caused the bruise. Size of bruise is about golfball." An entry at 11:30 a.m., also by Executive Director A, documented that s/he went to see Resident 2 and look at his/her bruise with

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the annotation: "Noted bruise to top of left forearm near wrist."

- 01/19/2024 (11:45 a.m., by RN Case Manager D): The entry documented a skin assessment that was completed by RN Case Manager D in response to the bruising concern raised the previous day. RN Case Manager D documented, " ...Writer observed a dark purple center on top left arm/wrist region the size of a golf ball with light purple surrounding the area ...When writer asked what happened, [s/he] stated, 'I might have fallen, but I don't know, I don't remember." Writer looked at right forearm/wrist area and observed 3 smaller dime-sized areas of discoloration, lighter purple in color ..."

Surveyor reviewed the investigation documents that the provider completed regarding Resident 2's bruising first observed on 01/18/2024. The investigation consisted of an assessment by RN Case Manager D and 9 written statements from staff. Seven of the staff either did not explicitly mention anything regarding Resident 2's skin injury concerns or reported that they were not aware of any skin injury concerns. One staff, Caregiver K, whose statement was dated 01/19/2024, documented, "I saw it thought it was a blood clots[sic]. [S/he] always had spots on [his/her] body. [S/he] never said it hurts. I never saw any blood." Another staff, Caregiver J, whose statement was dated 01/19/2024, documented, "I [Caregiver J] continually have seem[sic] the bruises on [Resident 2] arms since 12/26/23 from the last incident report that I written. I didn't realize that those were New[sic] bruises." RN Case Manager D's assessment documented the same injuries as s/he documented in the observation note above (from 01/19/2024) and also included the following information:

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N 431	Continued From page 32 - Left forearm bruise: " ...States unsure how [s/he] got them[sic]." - Right forearm bruises (3): " ...Does not look like hand or finger marks. No other marks noted on arms or other body parts. [Resident 2] again unsure where came from." - "[Left] forearm does have bracelet and [right] watch noticed without concern ...Last fall was on 12/26/23. [Resident 2] does have chair transfer bar on [his/her] left side [s/he] could have bumped arm on or had sitting on while [s/he] slept." Surveyor reviewed the provider's on-hand hospice records for Resident 2, which appeared to contain a couple of visit notes that occurred from August 2023 - January 2024. In the available notes, there was no information about skin or injury concerns. Surveyor reviewed Resident 2's ISPs for 2023. One was dated as reviewed on 02/20/2023 and the most recent one prior to his/her discharge was dated as reviewed on 10/06/2023. Both identified that [Resident 2] required "full assistance" of 1 staff for dressing and toileting. The ISP from 02/20/2023 identified wound care needs related to a blister Resident 2 had on his/her right foot, but otherwise no skin care information or needs were identified on either ISP. On 02/14/2024, at approximately 12:10 p.m., Surveyor interviewed Executive Director A, Director of Health and Wellness C, and RN Case Manager D. Executive Director A reported that Resident 2 was occasionally reliable to report the sources of his/her injuries. When asked about the above skin injuries noted in Resident 2's	N 431		

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N 431	Continued From page 33 12/28/2023 observation note (documented above), RN Case Manager D reported s/he recalled being informed by Caregiver J about Resident 2's left upper extremity skin concern, which was a bruise near his/her hand. RN Case Manager D reported s/he completed an in-person assessment of Resident 2's skin the following day, on 12/29/2023, and determined that the bruise had likely occurred due to Resident 2 hitting his/her hand on a doorway while s/he was going through in his/her wheelchair. RN Case Manager D reported that Caregiver J did not relay any information about a left lower extremity scratch. RN Case Manager D confirmed s/he did not document this assessment. Regarding the 01/18/2024 - 01/19/2024 investigation into Resident 2's bruises, Executive Director A reported s/he was first alerted to Resident 2 having bruising concerns when a supervisor from Resident 2's hospice agency called him/her on 01/18/2024 to tell him/her that a hospice RN observed a bruise on Resident 2's left wrist during a standard visit on that day. Executive Director A reported that the hospice supervisor told him/her that they would be investigating, and in turn, Executive Director A told the supervisor that s/he would also initiate an investigation. Executive Director A reported that on 01/19/2024, Person L, who was Resident 2's activated power of attorney for healthcare (POA), and Person M, who was Resident 2's family member, came to the facility and told him/her that they were wanting to move Resident 2 out of the facility due to not feeling like s/he was safe as evidenced by the various bruises s/he had sustained. RN Case Manager D confirmed s/he assessed Resident 2's body on 01/19/2024 and did not discover any other skin marks than what s/he identified in his/her assessment (documented above). Executive Director A reported that the next Monday	N 431		

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N 431	Continued From page 34 (01/22/2024), Persons L and M brought up concerns regarding scabbing/bruising that was discovered by hospital staff on the top of Resident 2's head. Executive Director A reported that Person M showed him/her pictures of Resident 2's head and after looking at them, s/he thought looked more like scabs as opposed to bruises. Executive Director A reported that s/he didn't think the scabs appeared to be concerning. Director of Health and Wellness C reported s/he thought the "scabs" appeared more like skin moles on Resident 2's head that s/he may have scratched. Director of Health and Wellness C reported s/he did not think they looked bad but confirmed that s/he did not see the pictures that Person M had taken. RN Case Manager D confirmed Surveyor's observation that s/he had completed a comprehensive skin assessment on 01/19/2024, but reported this did not include observations of Resident 2's head because Resident 2 was wearing a wig. Executive Director A reported that the provider's investigation, as well as Resident 2's hospice agency investigation, concluded the observed injuries were of unknown origin and they did not substantiate any concerns of abuse. At approximately 12:48 p.m., Surveyor interviewed RN Case Manager D about Resident 2's incident report from 12/26/2023 (documented above), which was documented as being completed by him/her. RN Case Manager D reported that s/he completed an in-person assessment of Resident 2 on 12/27/2023. RN Case Manager D confirmed having observed the injuries documented, which included bruising and rug burn to Resident 2's "right arm/hand" and right knee. RN Case Manager D reported s/he could not recall if there were any left upper or lower extremity skin injuries to Resident 2.	N 431		

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N 431	Continued From page 35 At approximately 1:48 p.m., Surveyor interviewed Executive Director A, Director of Health and Wellness C, and RN Case Manager D again. All 3 confirmed that they were unaware of any recurrent skin issues experienced by Resident 2, including bruising. On 02/23/2024, Surveyor reviewed outside hospice records obtained for Resident 2. Surveyor observed the following skin concerns identified by hospice staff during hospice visits and reviewed the provider's record for Resident 2 for corroborating information. 1. 09/20/2023: RN visit note documented, "patient had a fall this morning, yellow colored bruise noted to right hip. Full [range of motion] noted, no pain or discomfort upon palpation." (There was no information in the provider's record for Resident 2 regarding the fall or any observed bruising to his/her right hip on or around 09/20/2023.) 2. 10/11/2023: Certified nursing assistant (CNA) visit note documented, " ...[Patient] was a little shaken this visit. [Patient] stated having fallen out of [his/her] bed prior to visit. [Patient] declined injury or pain, but stated feeling jittery. [Patient] does have a bruise on the right side of [his/her] neck [s/he] thinks has been there for a couple days." The visit time was documented as 6:00 p.m. - 6:40 p.m. (Surveyor observed that this bruising observation correlated with the "large purple bruise on rightside[sic] of neck" from Resident 2's observation note that day, documented above, but that the observation entry was made at 8:30 a.m., approximately 9.5 hours prior to the hospice CNA's visit.)	N 431		

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N 431	Continued From page 36 3. 10/12/2023: RN visit note documented, "Patient noted to have bruising to right arm, right eye, coccyx, left hip. Unsure of when bruising occurred or if it was from fall on 10/11 or 10/12. Staff did not notify [hospice agency] of fall on 10/11." The note also documented that bruising was observed at Resident 2's right neck and that Executive Director A had reported that between the afternoon/evening of 10/11/2023 and the morning of 10/12/2023, Resident 2 fell 3 times by slipping out of his/her chair each time. The note also documented, "Writer collaborated with facility staff [Concierge N] prior to visiting with patient ... [S/he] reports that patient has a bruise on the right side of [his/her] neck. [S/he] reports that the bruise was there yesterday ...[Concierge N] states [s/he]'s not sure how [s/he] got the bruise to [his/her] right neck ...Bruise on right neck appears to be from [his/her] oxygen tubing ...Patient reported that [s/he] had to go to the bathroom. Writer walked with patient to the bathroom. Patient noted to have a bruise on [his/her] coccyx, left hip, and right forearm ..." (From the correlating provider's notes for Resident 2, documented above, only 1 fall was documented as occurring between 10/11/2023 - 10/12/2023, and that fall resulted in bruising to Resident 2's right eye and right arm, with specific mention that no other injuries were noted. No information about coccyx and left hip bruising was documented.) 4. 10/13/2023: RN visit note documented that hospice was called due to Resident 2 having a fall that morning. The note documented, " ...Patient still has bruising to right side of neck, right eye, coccyx, scattered small bruising to arms, and bruise to left side of hip. (All from falls on 10/12, no new bruising noted from fall)." (From the correlating provider's notes for Resident 2, a fall	N 431		

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was documented as occurring on 10/13/2023 at 6:07 a.m. but no other information about the fall or resulting assessment was documented. There continued to be no documented information about left hip and coccyx bruising. There was no information regarding any additional bruising observed on Resident 2's arms, as documented by the hospice RN, and by extension, no clarification to the inconsistency on when the "scattered small bruises" on both arms were observed - either 10/12/2023 or 10/13/2023.)

5. 10/18/2023: RN visit note documented, "Right occipital bruise and bilateral forearm bruising noted from a fall on Saturday according to facility staff ...Fall prevention measures discussed with [Caregiver H]." (From the correlating provider's notes for Resident 2, no information about a fall that occurred on Saturday, 10/14/2023, was documented. There was no information about any observed right occipital bruising. There continued to be no documented information about left forearm bruising, and no documentation on whether right forearm bruising was new for 10/18/2023 or observed to be the same "right arm" bruising documented from Resident 2's fall on 10/12/2023.)

6. 10/26/2023: RN visit note documented, " ...healing bruise around left eye ..." (From the correlating provider's notes for Resident 2, there was no information about left eye bruising.)

7. 11/16/2023: RN visit note documented, "[Community Director E], facility director reports [patient] had a fall this morning ...[Patient] sustained a small skin tear to [right] elbow. Writer cleaned and dressed wound. Wound care orders received from [medical provider]." The skin tear was marked in the hospice records as being

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healed on 12/28/2023, 6 weeks later. (From the correlating provider's notes for Resident 2, a fall that resulted in a skin tear to Resident 2's right "forearm", was documented in an incident report dated 11/16/2023. No other information about the skin tear or the resulting wound care that was warranted was documented.)

8. 11/23/2023: RN visit note documented, "Bruises on back healing." (From the correlating provider's notes for Resident 2, there had not been documentation of any bruising observed on Resident 2's back. By extension, there was no clarification as to whether the back bruises were new or related to coccyx bruising that hospice nurses observed over 1 month ago, from 10/12/2023 - 10/13/2023.)

9. 12/26/2023: Telephone encounter note documented that at 9:40 a.m., Caregiver J called due to a "skin issue." The note documented, "[Caregiver J] calls to report a resident came and found [him/her] to report [Resident 2] has a large bruise. [Caregiver J] states s/he went to the room and also notes bruising from [his/her] right hand up through [his/her] forearm. [S/he] has no pain. The [patient] couldn't recall how [s/he] got it and there have been no known falls. There are no blood thinners on [patient]'s [medication administration record] ..."

The resultant RN visit note that day documented, "Check in with facility caregiver [Caregiver J] who reports new bruising noticed this morning on patient's right arm. Seen first on hand, and when [s/he] asked to pull up patient's sleeve, [s/he] noticed bruising all the way to upper arm above elbow ...Patient noted to NOT be on blood thinners. Patient agreeable to visit. Denies fall or injury to arms. Bruises noted to be on bilateral

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arms, both upper and lower arms and hands. Bruising to bilateral hands over posterior aspect of hand near base of thumb, deep purple in color. Bruises to forearms and upper arms each approximately 3-5 cm in diameter with various shades of deep red to purple ...Skin tear noted just superior to right elbow ...Small amount of serosanguinous drainage noted on sleeve of patient's shirt from skin tear, but patient declines dressing." The nurse also documented, " ...recommend continued monitoring at this time ...Training provided: call [hospice agency] with questions/concerns, possible causes of bruising ..."

A hospice social worker visit that day documented, "[Resident 2] points out that [s/he] does have bruises, but [s/he] is not sure where they came from. [S/he] has had a fall in the past couple of weeks. [S/he] stated that they only bother [him/her] when [s/he] touches them."

(From the correlating provider's notes for Resident 2, an unwitnessed fall that resulted in bruising and rug burn to Resident 2's "right arm/hand" and right knee was documented in an incident report dated 12/26/2023. The incident report documented that the source of the information about this unwitnessed fall was "Per [hospice agency] RN who came out to see resident today, that resident told [him/her] [s/he] had a fall earlier this morning." Surveyor observed this was inconsistent with the hospice RN's note, above, which documented that Resident 2 reported s/he couldn't recall how bruising appeared and "there have been no known falls." No information about the extent of the right "arm/hand" bruising was documented in Resident 2's record. No information about any open skin tears with resulting drainage was

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documented in Resident 2's record. There was also no information documented about bruising on Resident 2's left upper extremity, despite the hospice RN's observation that same day of various bruises on his/her left upper arm, forearm, and hand ranging from 3-5 cm in diameter. Of note, Caregiver J wrote in his/her 01/19/2024 statement from the 01/18/2024 bruising investigation, documented above, "I [Caregiver J] continually have seem[sic] the bruises on [Resident 2] arms since 12/26/23 from the last incident report that I written," indicating awareness of "bruises" (plural) on "arms" (plural). There was no information documented how the provider planned to monitor Resident 2 and his/her bruising in accordance with the hospice RN's recommendation.)

10. 12/27/2023: CNA visit note documented within his/her skin observations, "[patient] has various small bruises and scrapes from a tumble [s/he] does not remember." (From the correlating provider's notes for Resident 2, the last fall was documented as occurring on 12/26/2023, noted above. No other information about the extent of the bruising, so as to ascertain whether the "various small bruises and scrapes" observed on 12/27/2023 were the same as those that occurred on 12/26/2023, was documented.)

11. 12/28/2023: RN visit note documented, " ...scattered bruisises[sic] on [bilateral upper extremities]." (From the correlating provider's notes for Resident 2, the only updated note about Resident 2's skin since the 12/26/2023 fall, as documented above, was on 12/28/2023 at 4:15 p.m. when Caregiver J documented, "[Resident 2] also has a scratch on [his/her] left leg from a few days ago when I reported to the [hospice agency] nurse concerning [his/her] left arm." Surveyor

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observed no other information about Resident 2's left leg "scratch" and no information about any "left arm" concerns from the provider's records.)

12. 01/02/2023: RN case manager update note, within Resident 2's hospice plan of care, documented, "New scattered bruises on [bilateral upper extremities]."

13. 01/04/2024: RN visit note documented, "Scattered bruises on [bilateral upper extremities]. Wound care provided to [right] arm." (From the correlating provider's notes for Resident 2, no skin tear at Resident 2's right arm that warranted wound care was documented around this time. The last note regarding Resident 2's skin bruising continued to be the incident report from 12/26/2023, where no left upper extremity injuries/bruises were ever noted.)

14. 01/10/2024: CNA visit note documented, " ... [patient] had bruising on [his/her] head and both [his/her] upper arms, a mark on [his/her] neck, and scratching marks on [his/her] arms." (From the correlating provider's notes for Resident 2, there was no information about any head bruising, neck marks, or scratching marks on Resident 2's arms. The last note regarding Resident 2's skin continued to be the incident report from 12/26/2023, where no left upper extremity injuries/bruises were ever noted.)

15. 01/16/2024: RN Case Manager note documented, "New skin tear noted on knee." (From the correlating provider's notes for Resident 2, there was no documented information about knee skin tearing. The last documented knee skin condition was the bruising and "rug burn" documented in the 12/26/2024 incident report.)

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16. 01/18/2024: RN visit note documented, " ...Checked in with [RN Case Manager D] via email; [RN Case Manager D] reports no new concerns for [Resident 2] other than increased confusion ...completed skin assessment ...Wound care done to [left] knee." The skin assessment documented, "Noted scattered purplish-red bruises to [right] forearm and elbow, including finger-shaped bruises to right forearm. Noted 2 yellow bruises less than dime sized to [right] scapula and underarm and 1 to [left] underarm. Noted yellow bruise approx quarter sized to crown of head."

A telephone call note from Resident 2's hospice social worker to Person L, dated the same day, documented, "[Hospice RN] visited with [Person L], [Person M], and [Resident 2] this morning at the facility. RN did notice injuries of unknown origin. This concern has been brought to leadership. Explained to [Person L] that due to the situation [hospice agency] leadership did need to bring this to the attention of Brightstar management for them to do an internal investigation. [Person L] has made arrangements for [Resident 2] to move to a new facility. [S/he] did ask that [hospice agency] not bring this up to Brightstar due to fear of retaliation toward [Resident 2]. Explained that due to the seriousness of the situation [hospice agency] did need to contact Brightstar."

(From the correlating provider's notes for Resident 2, the last information regarding Resident 2's skin was the 12/28/2023 observation note, approximately 3 weeks prior, regarding a left leg scratch and unspecified "left arm" concern. Prior to that, the only documented skin information was the 12/26/2023 incident report

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which documented bruising and rug burn to Resident 2's "right arm/hand" (extent unspecified) and right knee. Prior to 12/26/2023, the most recent documented skin concern was the right forearm skin tear almost 1 month prior on 11/16/2023. The provider's investigation, including RN Case Manager D's skin assessment of Resident 2 on 01/19/2024, did not identify right scapula bruising, right underarm bruising, left underarm bruising, or head bruising, despite having been observed the day after the hospice RN's skin assessment which identified these areas of concern. Observation notes for Resident 2 from 01/18/2023 through her discharge on 01/22/2024, did not identify right scapula bruising, right underarm bruising, left underarm bruising, or head bruising. No other skin concerns were documented, despite Caregiver K's 01/19/2024 written statement, referenced earlier, thinking that Resident 2 had visible blood clots, and Caregiver J's 01/19/2024 written statement, also referenced earlier, that s/he had "continually" seen bruises on Resident 2's arms since 12/26/2023.)

On 02/28/2024, at approximately 10:00 a.m., Surveyor interviewed Executive Director A, Director of Health and Wellness C, RN Case Manager D, and Community Director E. RN Case Manager D confirmed that the provider did not have any other hospice records for Resident 2 other than what was provided to Surveyor on site. When asked about skin monitoring, Director of Health and Wellness C reported that a general expectation is for staff to monitor residents' skin during cares and report or document any observed changes. All 4 staff interviewed denied awareness of the extent of Resident 2's skin injuries that had been observed by hospice. Executive Director A reported that s/he thought there was maybe some communication

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breakdown between hospice staff and the provider's staff. Executive Director A acknowledged Surveyor's concern regarding the lack of skin monitoring completed by staff. Executive Director A reported that they had all become aware of this being a concern from when Surveyor was on site on 02/14/2024 and that they were working on updating the provider's procedures related to resident monitoring. When Surveyor reviewed the provider's investigation of Resident 2's bruises, including the statements by Caregivers K and J, who had confirmed having seen "spots" and bruises on Resident 2, Executive Director A confirmed that there was no follow up questioning or information obtained to identify the extent of these known changes in Resident 2's skin.

Example 3 - Resident 4

On 02/14/2024, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 10/01/2019 with diagnoses including history of pulmonary embolism and essential hypertension. Resident 4's prescriptions included Metoprolol tartrate 25 mg tablets with instructions to, "Take 1/2 tablet (12.5 mg) by mouth twice daily for hypertension (may crush) HOLD MEDICATION IF BLOOD PRESSURE TOP NUMBER IS LESS THAN 110." Resident 4's medication administration records (MARs) from 01/18/2024 (when the prescription with the hold parameters in the instructions began) through 02/13/2024 showed that Resident 4's Metoprolol was assigned to be administered at 8:00 a.m. and 8:00 p.m. Surveyor reviewed Resident 4's MARs from 01/18/2024 - 02/13/2024 as well as Resident 4's vitals history document, both of which contained recordings of Resident 4's blood pressures. Surveyor did not observe any

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N 431	Continued From page 45 documented blood pressure readings for the following 15 dates/times despite staff documenting having administered Resident 4's Metoprolol: - 01/21/2024 (8:00 p.m.) - 01/22/2024 (8:00 p.m.) - 01/23/2024 (8:00 p.m.) - 01/26/2024 (8:00 p.m.) - 01/27/2024 (8:00 p.m.) - 01/28/2024 (8:00 p.m.) - 01/30/2024 (8:00 a.m.) - 01/31/2024 (8:00 p.m.) - 02/02/2024 (8:00 p.m.) - 02/03/2024 (8:00 p.m.) - 02/04/2024 (8:00 a.m.) - 02/06/2024 (8:00 p.m.) - 02/07/2024 (8:00 p.m.) - 02/08/2024 (8:00 p.m.) - 02/12/2024 (8:00 p.m.) On 02/14/2024, at approximately 2:35 p.m., Surveyor interviewed Executive Director A, Director of Health and Wellness C, and RN Case Manager D. RN Case Manager D confirmed that the hold parameter for Resident 4's Metoprolol was set by his/her medical provider. RN Case Manager D reported s/he was aware of a previous issue regarding staff inconsistently documenting Resident 4's blood pressures but thought s/he had fixed this in the provider's electronic record platform. RN Case Manager D reported that s/he would have to look into this.	N 431		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive	N 488		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017372	A. BUILDING: _____ B. WING _____	R-C 02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR SENIOR LIVING OF WAUNAKEE	1001 QUINN DR WAUNAKEE, WI 53597

(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 488	Continued From page 46	N 488		

rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that the clothes dryer vent tubing was constructed of rigid material.

This is a repeat deficiency. See Statement of Deficiency (SOD) PI0511, dated 09/27/2023.

Findings include:

On 02/16/2024, at approximately 12:34 p.m., Surveyor reviewed photos sent by Executive Director A of the provider's clothes dryer vent tubing. The vent tubing appeared to be made of a semi-rigid material.

On 02/16/2024, at approximately 10:00 a.m., Surveyor interviewed Executive Director A about the dryer vent tubing. Executive Director A reported that after the last survey, s/he spoke with the provider's maintenance staff about installing rigid vent tubing and thought new tubing, which was rigid, was installed that day. Executive Director A reported that s/he would follow up with maintenance staff for additional information about the dryer vent tubing and then follow up with Surveyor.

On 02/16/2024, at approximately 12:06 p.m., Executive Director A called Surveyor. Executive Director A reported that s/he spoke with maintenance staff, and confirmed that semi-rigid, not rigid, dryer vent tubing was installed. Executive Director A reported s/he planned to

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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 488	Continued From page 47 have the dryer vent tubing replaced with rigid material when the maintenance staff came in for work next.	N 488		