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	0014137	A. BUILDING: _____ B. WING _____	C 06/10/2024

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VAN DYKE	1811 S VAN DYKE RD APPLETON, WI 54914

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N 000	Initial Comments On 05/24/2024, with information gathered through 06/10/2024, Surveyor conducted a standard licensure survey, a complaint investigation and a self-report review at Van Dyke. Eleven deficiencies were identified. Complaint was substantiated. Census: 7	N 000		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the Department within 3 working days when Resident 4 suffered a burn due to caregiver misconduct. Findings include: On 01/17/2024, the Department received a concern alleging a resident had sustained burns requiring emergency treatment due to caregiver misconduct. On 05/24/2024, at approximately 1:00 PM, Surveyor interviewed Care Management Director (CMD) A and Team Lead B. CMD A explained that Direct Support Person (DSP) C had placed Resident 4's nebulizer machine directly on	N 165		

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

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N 165	Continued From page 1 Resident 4's bed, covered with a blanket, causing the machine to overheat and burn Resident 4 on his/her side/stomach area. Surveyor requested Resident 4's record. On 05/26/2024, Surveyor reviewed Resident 4's record: Resident 4's "Incident Report," dated 01/14/2024 at 7:13 AM, written by DSP C, documented: "Writer passed resident's breathing treatment, writer put breathing treatment air pump in bed with resident to keep resident from pulling the pump off the dresser. Resident then proceeded to pull the tube out of the mask (several times), when the writer would check on the resident the treatment wasn't being actually done, writer would reconnect the air tube. After about an hour writer heard the resident crying out, this is common, so the writer continued with tasks and then when finished checked on resident. Writer noticed the pump was running really loud, was covered in the blankets, was extremely hot, and pressed against the resident. Writer noticed some reddening but nothing serious at the time. Resident appeared to be okay, didn't seem to be in pain and shortly after fell asleep, writer checked on resident's brief through the night and resident was mostly dry. When writer went to change resident's brief after feeding was completed, writer noticed the reddening had worsened and the skin blistered." "Did injuries require outside medical care: No" Resident 4's medical documentation, dated 01/14/2024 at 1:20 PM, documented: " ...On the right side of the anterior abdomen and on the right lateral side of the abdomen there is a region of second-degree partial-thickness burn without any blistering. ... Due to the size of the burn I will refer [him/her] to wound care for	N 165		

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N 165	Continued From page 2 follow-up. This burn is approximately 3-5% BSA (body surface area) ..." On 05/26/2024, Surveyor reviewed the Department file and noted that no written reports had been submitted to the Department from 10/04/2016 until 02/29/2024, when Resident 4 sustained an injury of unknown injury, a broken femur. On 06/10/2024 at 4:30 PM, Surveyor interviewed Division Administrator D. Division Administrator D stated s/he was still learning when a written report needs to be submitted to the Department. S/he stated s/he would review the requirements with management.	N 165		
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 observation, record review and interview, the provider did not ensure 2 of 2 residents received adequate treatment after displaying a change-in-condition. Resident 4 displayed pain and bruising and did not receive emergency treatment for 3 days. Resident 4 was diagnosed with a fractured femur. Direct Support Person (DSP) C placed Resident 4's nebulizer next to him/her in his/her bed for two	N 353		

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N 353	Continued From page 3 hours, which resulted in a second-degree burn. DSP E did not initiate Resident 4's scheduled 6:00 AM g-tube feeding. Team Lead B realized the feeding had not been started when s/he arrived at work after 10:00 AM and initiated the feeding. Resident 5 displayed discoloration of the skin that appeared to be bruising along his/her back and was to be seen by his/her primary care physician (PCP). Resident 5 did not see his/her PCP for 3 weeks. Findings include: On 01/17/2024, the Department received a concern alleging a resident did not receive adequate treatment. Example 1: Resident 4 - Fractured Femur On 05/24/2024, at approximately 1:00 PM, Surveyor interviewed Care Management Director (CMD) A and Team Lead B. Surveyor discussed the general concerns received by the Department. CMD A stated s/he was aware of specific concerns related to Resident 4. CMD A stated Resident 4 had gone to his/her day program, which was located at the managed care organization (MCO) facility. Staff at the MCO were providing peri cares to Resident 4 and they observed bruising and it was determined that Resident 4 should receive medical services. Resident 4 was taken to the hospital where it was determined s/he had a broken femur. Surveyor requested Resident 4's record. Resident 4 moved into the facility, 10/01/2003, with diagnosis including spastic diplegic cerebral	N 353		

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palsy (a form of cerebral palsy that causes muscle stiffness and spasms in a person's legs and, sometimes, arms).

Resident 4's "Observations" documented:
02/26/2024 2:30 PM, written by Team Lead B: "[Resident 4] was doing a lot of yelling, so I thought maybe [s/he] wanted to go lay down since it was around the time [s/he] usually lays down. When I got [him/her] in bed [s/he] was still yelling out. I called [CMD A] to come and see if [s/he] could figure out what was going on since [s/he] knows [him/her] better than I do. [S/he] came in and looked [him/her] over we didn't notice anything physically wrong no bruising or nothing. [S/he] said give [him/her] ibuprofen and see if that helps. I did tell the next shift staff to keep an eye on [him/her] and give ibuprofen if needed."
02/28/2024 7:30 AM, written by Team Lead B: "This morning when I came in, [Direct Support Person (DSP) C] reported to me that something seemed wrong with [Resident 4's] leg because it was very loose when [s/he] was getting [him/her] up and ready for [day program]. Usually [Resident 4] is more stiff in the legs. [Resident 4] was not yelling out when I went to give [Resident 4] [his/her] morning meds [s/he] was laughing at me and seemed in good spirits."

Surveyor documented 2 of 3 observations recorded for February 2024.

On 05/26/2024, Surveyor reviewed supporting Adult Protective Services (APS) documentation that had been submitted with the concern called into the Department which documented: "02/28/2024: [Resident 4] went to day programming ... for the first time in about a month. When [s/he] arrived, [Resident 4] was

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vocalizing like [s/he] was in discomfort so staff at [MCO] began changing [his/her] Depends. Upon undressing ... staff notices a large dark purple bruise across [his/her] groin as well as swelling and redness to [his/her] right leg ... was sent to [hospital] where [s/he] was diagnosed with a shattered right femur, blood clot and impacted bowel. Hospital staff estimated [Resident 4's] injuries were 2-3 days old and would have been readily visible to anyone providing cares to [him/her]."
APS included the police report that was filed regarding a welfare check on Resident 4 which documented:
02/28/2024, written by Police Officer O - "I responded to a hospital for a report of a client with an unexplained injury. I conducted follow up regarding incident:
[Division Administrator (DA) D] - [DA D] advised when [s/he] was able to see [Resident 4], [s/he] has bruising on [his/her] right leg by [his/her] pelvic area which looks like it could be from the Hoyer lift strap. [DA D] explained the Hoyer lift can be applied with only one person. [DA D] described the bruising as deep purple and noticeable if you were to change [Resident 4].
[MCO Care Manager (CM) I] - [MCO CM I] advised [MCO CM H] was using the Hoyer lift and [s/he] noticed [Resident 4's] right leg just hung there. Once [Resident 4] was on the changing table/mat, they rolled [Resident 4] to [his/her] side ... noticed [Resident 4] had bed sores. [MCO CM I] stated [s/he] put some AD cream on the sores. ... [MCO CM I] advised once [Resident 4] was rolled onto [his/her] back [s/he] noticed the bruising and swollen groin area. [MCO CM I] advised when they were changing [Resident 4], [s/he] was crying/moaning out in pain. [MCO CM I] described [Resident 4] as a happy go lucky [guy/gal]. [MCO CM I] stated an ambulance was

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called to transport [Resident 4] to the hospital." 02/29/2024, written by Police Officer O - I responded to [provider] office to meet with [DA D] and [CMD A]. [CMD A] advised [s/he] had just came from the hospital, and [Resident 4] was seen by the [Surgeon J]. [CMD A] advised [s/he] was informed [Resident 4] has Osteoporosis and [Surgeon J] was stating this break was consistent with caregiver error. ... [CMD A] advised [Resident 4] was currently septic.

On 05/26/2024, Surveyor requested Resident 4's MCO record from the organization.

On 05/31/2024, Surveyor reviewed Resident 4's MCO record documented:
"02/28/2024 - Received a call from [MCO CM I] [s/he] stated [Resident 4] had returned from being out from serval [sic: several] weeks due to a broken chair. Upon changing [him/her] [s/he] noticed that [his/her] pubic area was bruised, [peri area] and buttocks had raw open areas and [his/her] upper thigh was swollen and firm. [S/he] felt [his/her] hip looked broken or dislocated and that [s/he] looked pale. We discussed the need for immediate intervention and it was decided that EMS (emergency medical service) would be called. [MCO CM I] stated that [s/he] would call [CMD A] and update [him/her] on [Resident 4's condition. ..."
"02/29/2024 - Correspondence received from [MCO] informing IDT (interdisciplinary team) of bruising, bedsores, swelling and possible dislocated/broken leg. ... CM (care manager) contacted [provider] and spoke with [Team Lead B]. [Team Lead B] reported that staff arrived Monday morning to find [Resident 4] yelling in [his/her] chair. Overnight staff (DSP E) immediately left and notified [Team Lead B] that [s/he] had quit. [Team Lead B] reported that staff

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assisted [Resident 4] into [his/her] bed and contacted [CMD A]. [CMD A] provided member with PRN (as needed) pain medication. [Team Lead B] reported that [s/he] checked [Resident 4] over to see why [s/he] was in distress and did not see any specific reason for [his/her] discomfort. [Resident 4] remained in bed most of the day Tuesday. [Team Lead B] stated that [Resident 4] was back to [his/her] 'normal' self Wednesday morning. Staff was unaware of any bruising or swelling. [Resident 4] was changed and then transferred to [his/her] wheelchair before leaving for [MCO - day program]. APS contacted CM and provided report of incident. APS will be conducting an investigation."

On 06/10/2024 at 4:30 PM, Surveyor interviewed DA D. DA D stated staff in the home should have noticed the bruising on Resident 4 prior to MCO staff noticing it. DA D stated when Resident 4's leg was no longer contracted, staff should have recognized that there was a concern that needed medical attention.

Example 2: Resident 4 - Nebulizer and G-Tube Feeding

On 01/17/2024, the Department received a concern alleging a resident had sustained a second degree burn due to staff misconduct.

On 05/24/2024, at approximately 12:45 PM, Surveyor interviewed Care Management Director (CMD) A and Team Lead B. Surveyor discussed the concern that had been filed with the Department. CMD A stated s/he was aware of the concern. CMD A stated DSP C had placed Resident 4's nebulizer machine on his/her bed, next to him/her, under his/her blankets. CMD A stated, "[Resident 4] had a habit of pulling

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[his/her] mask off, so [DSP C] thought maybe if [s/he] put the machine next to [him/her], [s/he] would leave it on." CMD A stated, "[DSP C] reported that [s/he] had heard [Resident 4] yelling, but [Resident 4] was always vocalizing. [Resident 4] is non-verbal, so staff do not respond every time [s/he] makes a sound. [DSP C] should never have placed the machine on [Resident 4's] bed. [DSP C] resigned shortly after the incident." Surveyor commented the concern mentioned that the nebulizer treatment was to be started at 8:00 PM, but it wasn't started until approximately 11:45 PM and left running until 2:00 AM. CMD A stated s/he was not aware the treatment had been started late. Surveyor requested Resident 4's record.

On 05/26/2024, Surveyor reviewed the police report documentation that had been submitted with the complaint for review which documented:
"02/28/2024: I responded to a hospital for a report of a client with an unexplained injury. I conducted follow up regarding incident ... I spoke with [Division Administrator (DA) D for the provider] ... [DA D] mentioned in January 2024 there was an incident where [Resident 4] sustained a 2nd degree burn on [his/her] right side as a caregiver put [Resident 4's] nebulizer on [him/her]. [Resident 4] advised the machine is supposed to be placed on a table when it is being administered as the machine can get hot. [DA D] stated [Resident 4] was going to the wound clinic for care."
"02/29/2024: [Team Lead B] stated on Friday, February 23, 2024, [s/he] would have left work around 1600 (4:00 PM) hours. ... [Team Lead B] stated this was the first weekend [DSP E] was working on [his/her] own ... Then on Monday morning, [DSP K] showed up 30 minutes late to relieve [DSP E]. ... [Team Lead B] stated around

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N 353	Continued From page 9 1000 (10:00 AM) hours, [s/he] called in to check and [CMD A] was at the residence. [Team Lead B] spoke with [CMD A], who asked [him/her] to come into work. ... when [s/he] got there noticed it was a mess. [Team Lead B] stated [s/he] saw [Resident 4], who was in [his/her] chair, but normally on Monday [s/he] was supposed to go to work. [Team Lead B] went into resident's room to assist [DSP K]. Once [s/he] got into the resident's room, [s/he] noticed the tube feeding, which was supposed to be started at 0600 (6:00 AM) hours, had not been done. [Team Lead B] got the feeding started. On 05/26/204, Surveyor reviewed Resident 4's record: Resident 4's "Incident Report," dated 01/14/2024 at 7:13 AM, written by DSP C, documented: "Writer passed resident's breathing treatment, writer put breathing treatment air pump in bed with resident to keep resident from pulling the pump off the dresser. Resident then proceeded to pull the tube out of the mask (several times), when the writer would check on the resident the treatment wasn't being actually done, writer would reconnect the air tube. After about an hour writer heard the resident crying out, this is common, so the writer continued with tasks and then when finished checked on resident. Writer noticed the pump was running really loud, was covered in the blankets, was extremely hot, and pressed against the resident. Writer noticed some reddening but nothing serious at the time. Resident appeared to be okay, didn't seem to be in pain and shortly after fell asleep, writer checked on resident's brief through the night and resident was mostly dry. When writer went to change resident's brief after feeding was completed, writer noticed the reddening had worsened and the skin blistered."	N 353		

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"Did injuries require outside medical care: No"

Resident 4's medical documentation, dated 01/14/2024 at 1:20 PM, documented:
" ...On the right side of the anterior abdomen and on the right lateral side of the abdomen there is a region of second-degree partial-thickness burn without any blistering. ... Due to the size of the burn I will refer [him/her] to wound care for follow-up. This burn is approximately 3-5% BSA (body surface area) ..."

On 06/10/2024 at 4:30 PM, Surveyor interviewed DA D. DA D stated DSP C should not have placed Resident 4's nebulizer machine in his/her bed or wait 2 hours to check on him/her; a nebulizer treatment lasts approximately 20 minutes. DA D stated s/he did not understand why a staff member would not complete a resident's feeding regimen. DA D stated these were example of caregiver neglect.

"Breathe through your mouth until all the medicine is used. This takes 5 to 20 minutes, depending on the device and medicine used. If needed, use a nose clip so that you breathe only through your mouth. Turn off the machine when done." (Source: Medline Plus website, How to use a Nebulizer, February 03, 2024, https://medlineplus.gov/ency/patientinstructions. (review date - May 26, 2024).)

Example 3: Resident 5

On 05/24/2024, at approximately 1:00 PM, Surveyor interviewed CMD A and Team Lead B. Surveyor discussed the concern that was called into the Department. CMD A stated s/he was aware of the concern. CMD A stated Resident 5 had discoloration of the skin on his/her left side,

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behind the knee to the shoulder, but upon further review it was determined that it was not bruising. Surveyor requested Resident 5's record.

Resident 5 moved into the facility on 11/03/2023.

Resident 5's "Observations" documented:
04/23/2024 - When changing [Resident 5], I noticed [s/he] had some skin discoloration on [his/her] left side from behind [his/her] knee to [his/her] shoulder. The home health nurse is coming in today, so waiting to see what they suggest we do.

On 05/26/2024, Surveyor requested Resident 5's APS record from the organization.

On 05/31/2024, Surveyor reviewed Resident 5's APS record documented:
"05/03/2024 written by [APS Social Worker (SW) L] - [Home health] reported [s/he] learned at a case review today the nurse going into the home documented seeing marks on [Resident 5] on 04/23/2024 and again on 04/30/2024. On 04/23/2024 the nurse observed discoloration running from [Resident 5's] shoulder to thigh. When the nurse asked [Team Lead B] about the marks, [Team Lead B] denied knowing anything about them saying [s/he] had just returned from a 2 week vacation. The nurse instructed [Team Lead B] to get [Resident 5] in to see [his/her] PCP (primary care physician) ASAP to have the marks looked at, but this was not done. On 04/30/2024 [Team Lead B] alerted the nurse to a bruise on [Resident 5's] left hip area. Writer met with [Team Lead B], [Division Administrator D], and [Resident 5] at the [home]. ... There have been 3 previous reports of bruising being found on [Resident 5] since November 2023 ... Staff admitted some of the bruising was caused by

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improperly rolling [Resident 5] while changing [him/her]. Harm in to form of bruising ... has been previously found to occur to [Resident 5] due to caregiver neglect. ... [Home Health] has been providing wound care services to [Resident 5] for the past few months. [Home Health] nurse documented seeing marks on [Resident 5], from [his/her] shoulder to thigh. The nurse reported [s/he] was unsure if the marks were bruises or something else and said when [s/he] asked [Team Lead B] about them [Team Lead B] said [s/he] knew nothing about them as [s/he'd] gotten back from vacation. The nurse reported [s/he] directed [Team Lead B] to call PCP [Doctor M] and schedule an appointment to have the marks examined. When questioned, [Team Lead B] confirmed [s/he] was on vacation until 04/23/2024, but asserted [s/he] was the one who alerted the [Home Health] nurse to the marks. [Team Lead B] also said [s/he] called [Doctor M's] office and was told to keep an eye on the marks, but did not have to bring [Resident 5] in. [Doctor M's] office records indicate they were contacted by [Home Health] about the marks and called the group home twice to try to get [Resident 5] brought in, but did not reach staff or get any return calls. [DA D] indicated [s/he] checked the phone records and there were indeed 2 incoming calls from [Doctor M's] office, however the staff working at the time did not know how to access the voice mail. [Resident 5's] [MCO CM] visited the home on 04/24/2024 and documented seeing the marks in question. MCO [CM N] reported the marks in question did not look like bruises, but looked like hyper-pigmentation to the skin ... [CM N] indicated [s/he] also instructed [Team Lead B] to contact [Doctor M] ...[Team Lead B] claimed [s/he] gave the spot a 'good scrub' and it seemed to improve, leading [him/her] to suspect it was dirt. [Team Lead B] asserted [s/he] spoke to

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N 353	Continued From page 13 [Doctor M's] nurse and was told [s/he] did not have to bring [Resident 5] in. ... [CM N] reported they received an email on 04/23/2024 from [Team Lead B] indicating when [s/he] changed [Resident 5] [s/he] noticed marks and that [s/he] had the [Home Health] nurse look at it. It should be noted that this is a different version of events than what [Home Health] provided as the [Home Health] staff reported they noticed the marks on [Resident 5] and when they ask [Team Lead B] about it [s/he] reported [s/he] had no idea where they had come from as [s/he] had been on vacation. Resident 5's record did not contain any medical documentation for April or May 2024. On 06/10/2024 at 4:30 PM, Surveyor interviewed DA D. DA D stated Resident 5 had not been seen by his/her physician regarding this incident. DA D explained that Resident 5 received a shower on 04/25/2024 and again on 04/28/2024, where they scrubbed the skin that displayed the discoloration and determined that the skin no longer looked darker in that area. On 04/30/2024, during a staff meeting, it was reported that Resident 5 no longer had discoloration of the skin. DA D stated it was then determined Resident 5 did not need to see his/her doctor. Surveyor summarized that the concern was first reported on 04/23/2024. The doctor was unable to reach the provider. On 04/28/2024, Resident 5 was given a thorough shower, when it was determined the skin discoloration was not bruising. DA D stated s/he understood that staff should not have waited 5 days to determine if Resident 5 needed to be seen by his/her physician. The shower should have been completed immediately to rule out other concerns.	N 353		

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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 observation, record review, and interview, the provider did not ensure 2 of 2 residents' Individual Service Plans (ISPs) were updated when there was a change of condition in the resident's physical condition. Resident 3's ISP was not updated to provide care guidelines for his/her CPAP (continuous positive airway pressure) machine resulting in him/her utilizing the machine when it had not been properly cleaned. Resident 5's ISP was not updated to provide care guidelines for his/her behaviors regarding personal cares. Findings include: Example 1: Resident 3	N 389		

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N 389	Continued From page 15 On 01/17/2024, the Department received a concern that residents sleep-aid devices were not properly cared for. On 05/24/2024, at approximately 11:15 AM, Surveyor toured Resident 3's room and observed his/her CPAP machine sitting on a nightstand, to the right of his/her bed. Surveyor noted the device was displaying a message that read, "Sleep Report: High leak detected, check your water tub, tub seal or side cover." On 05/24/2024, at approximately 1:15 PM, Surveyor interviewed Care Management Director (CMD) A and Team Lead B. Surveyor explained the concern that had been reported to the Department. CMD A stated s/he was aware of the concern and that it had been addressed. Surveyor explained the reading that s/he observed on Resident 3's CPAP. CMD A stated s/he would have staff look at the device. Surveyor requested Resident 3's record. "Sometimes, a high leak rate will trigger your machine's AutoStop function if it is enabled, so you'll want to check your entire PAP circuit for leaks. This means your tubing, mask, and all connection points along the way. Also double-check your humidifier tub and make sure it's pushed all the way in and seated properly, as this can also be a source of major air leakage." (Source: CPAP website, Your Guide to ResMed AirSense 10 Troubleshooting, August 18th, 2023, https://www.cpap.com/blog/resmed-airsense-10-troubleshooting (retrieval date - May 27, 2024).) On 05/26/2024, Surveyor reviewed Resident 3's record. Resident 3 moved into the facility, 07/10/1995,	N 389		

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N 389	Continued From page 16 with diagnosis including sleep apnea. Resident 3's ISP, dated 02/05/2024, documented: "Sleep Monitoring/Sleep Pattern: [Resident 3] does where [sic: wear] a CPAP mask at night, [s/he] needs assistance with filling up [his/her] machine with water and putting [his/her] mask on. [Resident 3's] CPAP machine will automatically turn on once [his/her] mask is properly put on." On 05/26/2024, Surveyor reviewed the adult protective services (APS) documentation that was submitted with the concern, which documented: "03/05/2024: Writer observed [Resident 3's] CPAP machine tank to be dirty and have pink slime in it. [Team Lead B] admitted [s/he] has never cleaned the CPAP machine and does not know if other staff have done so. Writer reviewed [Resident 3's] care plan which addresses cleaning [his/her] CPAP mask and adding water to the chamber, but not cleaning [his/her] chamber." On 06/10/2024 at 4:30 PM, Surveyor interviewed Division Administrator (DA) D. DA D stated s/he would review Resident 3's ISP to ensure proper guidance was provided regarding his/her CPAP. Example 2: Resident 5 On 05/24/2024, at approximately 10:55 AM, Surveyor observed Resident 5's room. Resident 5 was sleeping. Surveyor noted Resident 5's room smelled strongly of a urine like scent. Surveyor observed Resident 5's laundry basket which contained soiled clothing that smelled of a urine like scent. Surveyor requested Resident 5's record.	N 389		

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N 389	Continued From page 17 Resident 5 moved into the facility on 11/03/2023 with diagnoses including diabetes, schizoaffective disorder, depression, and anxiety. Resident 5's "Observations" documented: 05/20/24 7:45 AM - tried changing [Resident 5] just now after giving [his/her] meds and [s/he] was punching and yelling so will try again in a little while. 05/11/24 8:15 PM - Every time I go in [Resident 5] room and give [him/her] medication and see if [s/he] needs to be changed and [s/he] let me give [him/her] medication but every time I try and change [him/her] [s/he] starts to scratch me and trying to punch me I tried to give it 15 to 20 mins and I would go back in and [s/he] would still do the same thing so [s/he] would not let me change [him/her]. 05/07/24 9:00 AM - changed [Resident 5] just now and was going to attempt to get [him/her] in the shower but [s/he] was scratching and hitting so i (sic) got [him/her] changed the best i (sic) could and left the room 04/08/24 1:45 PM - Just went to change [Resident 5] as [s/he] was wet and has some Jevity on [his/her] sheets, i did get to change [his/her] depend but [s/he] started scratching and hitting me so i (sic) did what I (sic) could. i (sic) will attempt to change her bedding again in a little while. 04/08/24 12:45 PM - Just turned [Resident 5] off [Resident 5's] feedings [sic] because [s/he] ripped it off 3x (3 times) since 7am. 03/27/24 9:00 AM - i (sic) went in tried to change [Resident 5] and [s/he] was scratching and trying to hit me i (sic) walked away and will try again at 9:30am 11/06/23 2:45 PM - When i (sic) went in to check on [Resident 5] [s/he] was very upset and said that [s/he] doesn't know why i put [him/her] in this	N 389		

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N 389	Continued From page 18 crazy place, i (sic) said well [family member name] put you here and [s/he] said [s/he] was going to yell and [him/her] and slap [him/her] in the face, ... i (sic) was going to change [him/her] and [s/he] said i (sic) did not know what i (sic) was doing and i (sic) was a dumb [explicative word] and only here to steal [his/her] money and that [religious figure] told [him/her] to kill me so [s/he] was going to slit my throat because [religious figure] told [him/her] to do it. [S/he] also did not like that I was cleaning [him/her] and told me to get out of [his/her] [explicative word] and that i (sic) was a pervert. ..." Resident 5's "Individual Service Plan," dated 11/14/2023, documented: "Aggressive/Combative: [Resident 5] is resistive to cares from time to time and [s/he] will kick, scratch, pinch and hit at staff. [S/he] will swear and yell at staff as well. Resident's Desired Outcomes: To have interventions in place that help alleviate behaviors." "Self-Abusive Behavior: [Resident 5] will pull and pinch at [his/her] g-tube." On 06/10/2024 at 4:30 PM, Surveyor interviewed DA D. Surveyor reviewed Resident 5's ISP with DA D and stated the ISP did not identify the interventions for Resident 5's aggressive/combative behavior. DA D stated s/he would review his/her ISP to ensure this information was included.	N 389		
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	N 431		

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N 431	Continued From page 19 under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 1 resident reviewed received appropriate health monitoring to meet his/her needs. Resident 1 displayed a rash that was not documented as monitored until his/her managed care organization (MCO) Registered Nurse (RN)	N 431		

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N 431	Continued From page 20 G observed the rash on Resident 1. Findings include: On 01/17/2024, the Department received a concern alleging a resident did not receive adequate treatment after displaying a rash. On 05/24/2024, at approximately 1:00 PM, Surveyor, Care Management Director (CMD) A and Team Lead B observed Resident 1 walking throughout the home, with no stockings on, and noted his/her legs and heels displayed significant dry peeling skin and an approximately 1-inch circular red mark on the back of each calve area. Team Lead B stated Resident 1 was diagnosed with eczema. Surveyor explained the concern that Resident 1 did not receive adequate treatment when s/he displayed a rash that appeared to be shingles. CMD A and Team Lead B stated they were aware of the concern and Resident 1 displayed the rash one day before the concern was brought to their attention. Team Lead B stated, "The rash looked like [his/her] eczema. [Resident 1] is very independent and does not always require assistance from staff." Surveyor requested Resident 1's record. On 05/26/2024, Surveyor reviewed Resident 1's record. Resident 1 moved into the facility, 07/08/2017, with diagnosis including psoriasis. Resident 1's "Individual Service Plan," dated 01/15/2024, documented: "Bathing: requires full assistance from staff to complete bathing tasks. [Resident 1] does need staff ask [him/her] to take a shower. This is done daily. [Resident 1] will sit on a shower bench	N 431		

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during [his/her] shower staff will wash [Resident 1's] hair and body - having [him/her] use the grab bars when [s/he] needs to stand to wash [his/her] peri area. Staff will assist [Resident 1] with drying off and then after the shower applying [his/her] lotion."

Resident 1's "Observations," dated 11/01/2023 to 05/24/2024, documented:
02/28/2024 2:45 PM, Written by [Team Lead B] - When looking [Resident 1] over it was noticed that [Resident 1] had a rash on [his/her] back the nurse from [MCO] thought it could be shingles, I think its [his/her] psoriasis. I did call [his/her] dermatologist and made [him/her] an appointment for March 18th.

Resident 1's medical documentation stated:
"03/01/2024 - Presents to clinic with 1 day history of rash to right back and right chest wall. ...
Assessment: Disseminated herpes zoster (shingles)."

On 05/28/2024, Surveyor reviewed Adult Protective Services (APS) documentation that had been submitted with the complaint which documented:
"03/05/2024 - [Resident 1] was examined as part of a larger APS investigation into the CBRF where [s/he] lives, due to injuries sustained by other residents in the home. Writer spoke with [Resident 1's] [MCO Case Manager (CM) F] who indicated their nurse completed a full body check of [Resident 1] and noted a significant rash on [his/her] back, which [s/he] felt was shingles. Staff at [provider] reported they were aware of the rash, but assumed it was eczema or dry skin and did not seek medical care. [Resident 1] was seen by [his/her] PCP (primary care physician), diagnosed with shingles and given medication,

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N 431	Continued From page 22 which has worked to clear the rash." On 06/10/2024 at 4:30 PM, Surveyor interviewed Division Administrator (DA) D. DA D stated when s/he saw Resident 1's skin s/he knew it was shingles and staff should have known that was not his/her psoriasis. DA D stated are to fill out skin assessments on shower days and reviewed Resident 1's shower reports. DA D stated staff had not reported any concerns and still do not have any reported concerns. Surveyor explained his/her observations of Residents 1's skin. DA D expressed frustrations that staff were not properly documenting resident concerns.	N 431		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not make weekly menus available to residents and/or staff and deviations from the planned could not be documented on the menu. Findings include: The provider is licensed to serve up to 8 residents in the client groups of physically disabled, advanced aged, developmentally disabled, irreversible dementia/Alzheimer's, emotionally	N 450		

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N 450	Continued From page 23 disturbed/mental illness, and traumatic brain injury. On 05/24/2024, from approximately 10:00 AM to 1:30 PM, Surveyor toured the facility and did not observe a weekly menu available to the residents and/or staff. On 05/24/2024, at approximately 11:15 AM, Surveyor observed Resident 1 and Resident 2 served lunch which consisted of a canned pasta product. On 05/24/2024, at approximately 1:15 PM, Surveyor interviewed Care Management Director (CMD) A and Team Lead B. Surveyor asked how residents and staff knew what meals were being offered as there was no menu available. CMD A stated Team Lead B determines what meal should be prepared and leaves the food items out for the staff. Team Lead B stated Resident 1 would often remove the menu, so staff stopped hanging it up. CMD A stated the menu would be made available to resident and staff. On 06/10/2024 at 4:30 PM, Surveyor interviewed Division Administrator D. Division Administrator D stated s/he would discuss the concern with staff to ensure resident's were aware of planned meals for the day and to ensure staff knew what was to be prepared.	N 450		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site,	N 452		

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N 452	Continued From page 24 according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not store food under sanitary conditions. Surveyor found food items in the refrigerator that were not properly sealed to avoid contamination; food packages stored in the dry food area were not sealed properly. The provider did not implement a system to identify when opened food was to be discarded for the prevention of food borne illnesses. Findings include: On 05/24/2024, at approximately 10:30 AM, Surveyor toured facility kitchen and observed the following: Refrigerator: An opened package of bacon that was not sealed and dated. An opened 12-ounce package of hotdogs that was not sealed and dated. An opened 1-pound bag of processed honey smoked turkey sandwich slices that was not	N 452		

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sealed and dated.
A sandwich size bag of what appeared to be colored carrots in water that was not dated.
A gallon size bag of what appeared to be colored carrots in water that was not dated.

Pantry:
An opened 32 ounce bag of honey nut whole grained cereal that was not sealed.
A bag of white onions that felt soft to the touch.

On 05/24/2024, at approximately 1:15 PM, Surveyor interviewed Care Management Director (CMD) A and Team Lead B. CMD A stated they would discuss the concern with staff, the importance of making sure food is adequately stored and dated.

"Time/temperature control for safety (TCS) guidelines indicate food prepared in a food establishment and held longer than a 24 hour period shall be marked to indicate the date or day by which the food is to be consumed on the premises, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Refrigerated, RTE (ready-to-eat)/TCS food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed or discarded." (US Food and Drug Administration (FDA) Food Code, 2017, Section 3-501.17)

"Ready-to-eat TCS food (foods that need time and temperature control for safety) can be stored for only seven days if it is held at 41 degrees Fahrenheit or lower. The count begins on the day

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N 452	Continued From page 26 the food was prepared or a commercial container was open. TCS foods includes milk and dairy products, eggs, meat (beef, pork, and lamb), poultry, fish, shellfish and crustaceans, baked potatoes, tofu or other soy protein, sprouts and sprout seeds, sliced melons, cut tomatoes, cut leafy greens, untreated garlic-and-oil mixtures, and cooked rice, beans, and vegetables." (ServSafe Coursebook, 7th edition, 2017, p. 1-7, p. 1-8, and p. 7-3). "Date marking is a way to control the growth of a bacteria called Listeria, which grows under refrigeration and is the third leading cause of death from foodborne illness in the United States." (Source: Wisconsin Food Code Fact Sheet, Date Marking of Ready-to-Eat Time-Temperature Control for Safety Foods, April 2022) On 06/10/2024 at 4:30 PM, Surveyor interviewed Division Administrator D. Division Administrator D stated s/he would remind staff all food is to be securely stored and dated when opened in the refrigerator.	N 452		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 1 of 1 resident room was clean and free from odors. Resident 2's room smelled strongly of a urine-like odor and his/her bed was made with sheets that	N 489		

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had a urine-like odor and had soiled laundry stacked in the laundry basket.

Findings include:

On 05/24/2024, at approximately 10:40 AM, Surveyor observed Resident 2's room as Team Lead B was bringing Resident 2 out to the kitchen area while utilizing a lift-to-stand. Surveyor noted Resident 2's bed was made and his/her room smelled strong of a urine-like odor. Surveyor smelled Resident 2's bedding and bedsheets which smelled of a urine-like odor. Surveyor observed Resident 2's laundry basket which contained soiled clothing that smelled of a urine-like odor. Surveyor requested Resident 2's record.

Resident 2 moved into the home on 01/29/2020 with diagnoses including benign prostatic hyperplasia with urinary obstruction and chronic constipation.

Resident 2's "Observations," dated 11/01/2023 to 05/24/2024 documented 2 entries. Neither entry was in reference to his/her incontinence.

Resident 2's "Individual Service Plan," dated 12/18/2023, documented:
"Toileting - for the most part is incontinent, staff do toilet [Resident 2] every 2-3 hours during the day, during the night staff check on [Resident 2] and if [s/he] is wet they will change [him/her] however majority of the time [s/he] is dry throughout the night."
"Housekeeping - [Resident 2] requires staff to complete housekeeping services. [His/her] room is organized and cleaned daily and deep cleaning will be done on Saturday's. [Resident 2] requires staff to complete laundry services. [His/her]

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N 489	Continued From page 28 laundry is washed several times a week due to incontinence, along with [his/her] bedding." On 05/24/2024, at approximately 11:30 AM, Surveyor interviewed Care Management Director (CMD) A and Team Lead B. CMD A stated s/he was aware of the concern of urine-like odors. Team Lead B stated s/he had just changed Resident 2 prior to the Surveyor entering the room and Resident 2's urine had a strong odor. Surveyor stated the bedding had a urine-like odor, along with the laundry basket full of soiled clothing. CMD A stated s/he would remind staff that bedding should be changed if a resident is incontinent and soiled clothing should not remain in the room, along with soiled Depends. On 06/10/2024 at 4:30 PM, Surveyor interviewed Division Administrator (DA) D. Surveyor explained his/her observations. DA D stated s/he would discuss the concerns with staff.	N 489		
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 that cleaning compounds and toxic substances were stored in a secure area. Findings include: On 05/24/2024, from approximately 10:00 AM to 1:30 PM, Surveyor toured facility, as residents	N 499		

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N 499	Continued From page 29 moved about freely, and observed the following: Common Area -A 40-ounce spray can of foaming glass cleaner. Laundry Room -A 70 pac bag of laundry detergent - mountain breeze scent. -A 22-ounce spray bottle of clothing stain remover. -A 1 pound container of disposable germicidal surface wipes. -A 40-ounce bottle of floor cleaner - lavender scented. -A 24-ounce bottle of toilet bowl cleaner. Resident Bathroom -A 6-ounce spray can of insect repellant. -A 7-ounce spray can of insect repellant. -A 24-ounce bottle of toilet bowl cleaner. Kitchen Sink Cabinet -A 22-ounce spray bottle of clothing stain remover. -A 40-ounce bottle of floor cleaner - lavender scented. -A 19-ounce spray can of disinfectant spray - early morning breeze scent. -A 23 fluid ounce bottle of dishwasher rinse aid. -An 11-ounce spray can of spider and scorpion killer. On 05/24/2024, at approximately 1:15 PM, Surveyor interviewed Care Management Director (CMD) A and Team Lead B. CMD A stated s/he understood that cleaning compounds were to be stored securely. CM D A looked at the kitchen sink cabinet and observed that the locking device on the cabinet had not been engaged.	N 499		

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N 499	Continued From page 30 On 06/10/2024 at 4:30 PM, Surveyor interviewed Division Administrator D. Division Administrator D stated s/he would remind staff that all cleaning supplies need to be secured.	N 499		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct at least one fire evacuation drill simulating the conditions during usual sleeping hours with both employees and residents in 2022 and 2023. Findings include: Facility is licensed as a Class CNA (nonambulatory) CBRF (Community-Based	N 525		

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N 525	Continued From page 31 Residential Facility), able to serve up to 8 residents in the client groups of physically disabled, advanced aged, developmentally disabled, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, and traumatic brain injury. On 05/24/2024, Surveyor reviewed the facility fire drills for 2022 and 2023 with Care Management Director (CMD) A and Team Lead B. The 06/17/2022 report documented the simulated drill during usual sleeping hours was conducted at 5:30 PM. Surveyor noted this time did not meet the requirement of a drill conducted during darkness. The 04/21/2022 report documented the simulated drill during usual sleeping hours was conducted at 5:30 AM, when residents are actively getting up in the morning. The report did not document a drill in 2023. CMD A and Team Lead B stated the residents are usually not sleeping at that time. CMD A stated s/he understood the simulated drill during hours of sleep needed to simulate normal sleeping hours. On 06/10/2024 at 4:30 PM, Surveyor interviewed Division Administrator D. Division Administrator D stated s/he had been informed by a previous surveyor that this drill needed to just simulate sleeping, so residents could go lie down in their bed and then get up and evacuate.	N 525		
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:	N 526		

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N 526	Continued From page 32 Based on record review and interview, the provider did not ensure evacuation drills, such as tornado, flooding or other emergency or disaster, were completed at least semi-annually in 2022 and 2023. Findings include: Facility is licensed as a Class CNA (nonambulatory) CBRF (Community-Based Residential Facility), able to serve up to 8 residents in the client groups of physically disabled, advanced aged, developmentally disabled, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, and traumatic brain injury. On 05/26/2024, Surveyor reviewed the provider's other evacuation drills for 2022 and 2023. Surveyor noted the provider completed only one drill per year. On 06/10/2024 at 4:30 PM, Surveyor interviewed Division Administrator D. Division Administrator D stated s/he would follow up with staff on that requirement.	N 526		
N 532	83.47(4)(b) Fire extinguishers: locations. A fire extinguisher shall be mounted on a wall or a post or in an unlocked wall cabinet used exclusively for that purpose. Fire extinguishers shall be clearly visible. The route to the fire extinguisher shall be unobstructed and the top of the fire extinguisher shall not be over 5 feet high. The extinguisher shall not be tied down, locked in a cabinet or placed in a closet or on the floor. Fire extinguishers on upper floors shall be located at the top of each stairway. Extinguishers	N 532		

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N 532	Continued From page 33 shall be located so the travel distance between extinguishers does not exceed 75 feet. The extinguisher on the kitchen floor level shall be mounted in or near the kitchen. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 2 of 2 fire extinguishers located near the kitchen were properly mounted. Findings include: On 05/24/2024, at approximately 12:30 PM, Surveyor conducted a tour of the facility with Care Management Director (CMD) A and Team Lead B. Surveyor observed the fire extinguishers located in and near the kitchen were sitting inside of a cabinet designed for fire extinguishers, but the cabinets did not contain a door to secure the fire extinguisher. CMD A stated s/he would discuss the concerns with maintenance and see if a type of bracket could be installed to secure the fire extinguishers. On 06/10/2024 at 4:30 PM, Surveyor interviewed Division Administrator D. Division Administrator D stated a maintenance order had been placed to have the fire extinguishers secured.	N 532		