STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	510330	A. BUILDING: _____ B. WING _____	C 07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MANOR	119 E 4TH ST N LADYSMITH, WI 54848

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 07/17/2025, Surveyor conducted a complaint investigation at Lake Manor. The complaint was substantiated. Two deficiencies were identified. Census: 12	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 Resident 1 received prompt and adequate treatment when s/he had a bloody nose and was dependent on supplemental oxygen. Resident 1 died from hypoxemia. Findings include: On 07/08/2025, the Department received a complaint that alleged staff did not call an ambulance for an emergency and the resident died. The provider is licensed to care for up to 20 residents in the client groups of: advanced age and irreversible dementia/Alzheimer's disease. On 07/17/2025, Surveyor reviewed a police report. Police Officer (PO) D documented the	N 353		

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

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N 353	Continued From page 1 following narrative, in part: "On June 20th, 2025 at approximately 04:13am reporting [PO D] of the Ladysmith Police Department along with [Deputy E] and [Deputy F] of the Rusk County Sheriffs Office responded to 119 E 4th ST North, Lake Manor assisted living [apartment #] in regards to a pulseless non-breathing individual. Before my arrival CNA (certified nursing assistant) worker advised that a [fe/male] resident had passed away from a bloody nose. I ([PO D]) arrived to the address listed above and entered the residence of apartment number [#]. I observed a [fe/male] subject half clothed and half exposed, with large amounts of blood on [him/her] sitting straight up in [his/her] chair unresponsive. It should be noted that the [fe/male] subject's skin was very pale and [his/her] fingers, toes and areas around the mouth appeared to start turning blue. [Fe/male] subject was identified as [Resident 1] ... I asked [Caregiver C] when was the last time that [s/he] saw [Resident 1] alive. [Caregiver C] stated the last time [s/he] saw [Resident 1] alive was at 2:30 a.m. [Caregiver C] informed me that [s/he] was on the phone with [his/her] boss from 2:30am - 3:00am and stated [Resident 1] appeared to be fine. [Caregiver C] stated that while being on the phone, [s/he] moved [Resident 1] from the bed to the chair, was getting [him/her] dressed and wiping blood off of [him/her]. [Caregiver C] said [Resident 1] requested to go to the hospital and get checked out. During this time, [Caregiver C] stated [s/he] had another resident called for [him/her], and went to check that resident. While checking in on [his/her] secondary resident [s/he] called [his/her] boss back asking what to do. [Caregiver C] said [his/her] boss advised [him/her] to go check on [Resident 1]. According to [Caregiver C], when [s/he] found [Resident 1] ,	N 353		

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N 353	Continued From page 2 [s/he] was sitting in [his/her] chair with [his/her] head 'dangling' to right side of [his/her] body ... According to [Caregiver C], [s/he] tapped [his/her] chest in a repeating manner and observed [Resident 1] twitch from this and after that, [Resident 1] 'went limp. '.. I asked [Caregiver C] if EMS (emergency medical services) was notified of [Resident 1's] condition after [Resident 1] requested to go to the hospital. [Caregiver C] said, 'no cause we thought it was just a bloody nose and we were trying to get the bloody nose to stop.' According to [Caregiver C], [Caregiver C's] boss said 'hold off on calling EMS because [his/her] breathing was fine, its just a bloody nose [sic] lets get the bleeding to stop.' [Caregiver C] informed me that when [s/he] was with [him/her] the first time around, [Resident 1] was developing blood clots in [his/her] mouth and [Caregiver C] would pull them out. [Caregiver C] said 'after that [s/he] was fine.' I then asked [Caregiver C] what time [s/he] found [Resident 1] unresponsive. [S/he] stated it was 4:08am ..." Investigator G documented the following supplemental narrative, in part: "On Tuesday, July 1, 2025, at approximately 1500 hours, [Investigator G], of the Ladysmith Police Department, conducted an interview at the Law Enforcement Center ... with [Caregiver C], in reference to a death that occurred at, Lake Manor ... I ([Investigator G]) met with [Caregiver C] and recorded the interview on my department issued body camera. I asked [Caregiver C] to tell me about the night [s/he] was working, and [Resident 1] died. [Caregiver C] explained [s/he] was in the kitchen cleaning, and [s/he] heard some grunting. [Caregiver C] stated [s/he] recognized it as [Resident 1] because [s/he] 'doesn't always talk.' [Caregiver C] stated [s/he] came out of the	N 353		

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kitchen, [Resident 1] was waving [him/her] to [his/her] room ... [Caregiver C] stated [s/he] went down there and [Resident 1] had [his/her] nose covered. [Caregiver C] stated '[s/he] had blood seeping out.' [Caregiver C] said this was [his/her] first time with a resident that had a nose bleed [sic]. [Caregiver C] said [s/he] called [Registered Nurse (RN) B], and told [him/her] [Resident 1] had a bloody nose. [RN B] told [Caregiver C] to put some pressure on it and grab some ice. [Caregiver C] stated [s/he] put some ice in a glove and handled [sic] it to [Resident 1]. [Resident 1] put the ice on [his/her] nose for about 15 minutes. [Caregiver C] stated this was at approximately 0200 hours. [Caregiver C] said [s/he] was with [Resident 1] from about 0200 hours to 0345 hours. [Caregiver C] said at that time [s/he] was called away to another residences [sic] room. [Caregiver C] explained [s/he] was with the other resident for about 10 minutes ... [Caregiver C] explained when [s/he] was with [Resident 1] prior to being called away, [s/he] was pulling 'gobs' of blood out of [his/her] nose and mouth. [Caregiver C] stated [Resident 1] had COPD (chronic obstructive pulmonary disease), [s/he] was on oxygen. [Caregiver C] stated they could not put the cannulas in [his/her] nose or it would start bleeding again. [Caregiver C] stated [s/he] had gotten it to stop. [Caregiver C] stated while [s/he] was with [Resident 1] for the 1 hour 45 minutes, [s/he] called [his/her] boss. Due to [him/her] not being sure what to do. [Caregiver C] stated [Director of Operations (DO) A] walked [him/her] through what to do. [Caregiver C] stated [DO A] told [him/her] to put pressure on [his/her] nose and tilt [his/her] head back. [Caregiver C] stated [Resident 1] was refusing to put [his/her] head back. [Caregiver C] stated [s/he] was unsure if [Resident 1] couldn't put [his/her] head back or didn't want to, because [s/he] was

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'stubborn.' [Caregiver C] said [Resident 1] was fine when [s/he] left [him/her] at 0345 hours ... [Caregiver C] stated they thought it was just a regular nose bleed. [Caregiver C] stated once [s/he] finished with the other resident, [s/he] called [DO A] back because [s/he] didn't know what to do. [Caregiver C] stated [s/he] was unsure if [s/he] should call the emergency or nonemergency number. [DO A] told [Caregiver C] to go check on [Resident 1] and make sure [s/he] still wants to go. [Caregiver C] stated that is when [s/he] found [Resident 1] leaning over the right side of [his/her] chair, unresponsive. [Caregiver C] told [DO A] about [Resident 1] being unresponsive. [DO A] told [Caregiver C] to call 911 ... I explained to [Caregiver C] that I had looked at [PO D's] report and [s/he] mentioned [DO A] telling [him/her] to clean [Resident 1] up. I asked [Caregiver C] to tell me about that. [Caregiver C] stated [Resident 1] had dried blood and wet blood on [him/her]. [Caregiver C] stated this was when [s/he] was 'still alive.' [Caregiver C] explained they wanted [him/her] to be at least 'a little presentable when EMT's (emergency medical technicians) got there, so [s/he] wasn't covered in blood.' [Caregiver C] stated while [s/he] attempted to get [him/her] dressed [s/he] tried cleaning [him/her] up. [S/he] did not want blood seeping through [his/her] clothing ... I asked [Caregiver C] what [Resident 1] was doing, when [s/he] left to go take care of the other resident. [Caregiver C] stated [Resident 1] was sitting in [his/her] chair. [Caregiver C] stated [s/he] told [him/her] to make sure [s/he] put [his/her] cannulas into [his/her] mouth, because [s/he] could not put them into [his/her] nose or [his/her] nose would start bleeding again ... I asked [Caregiver C] where the cannula was when [s/he] came back to the room. [Caregiver C] stated it was under [his/her] arm. When [Caregiver C] left

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N 353	Continued From page 5 [him/her] to go help the other resident [Resident 1] was holding it, sitting forward looking at the floor. [Caregiver C] stated [s/he] made sure [s/he] had it in [his/her] hand. I asked [Caregiver C] what the garbage can was full of, because there looked to be a lot of blood in the garbage can, [Caregiver C] stated those are white balls. [S/he] used them to get blood clot out of [his/her] nose. This was to make sure [s/he] could breath [sic] ... [Caregiver C] stated [DO A] said it was probably a 'normal' nose bleed, and didn't seem too worried about it. [DO A] just wanted [Caregiver C] to get the bleeding to stop. [Caregiver C] stated for about ½ hours, it didn't stop. I asked [Caregiver C] when [Resident 1] asked for an ambulance. [Caregiver C] stated [Resident 1] didn't really ask for one at that time. [Caregiver C] stated [s/he] asked [him/her] if [s/he] would feel more comfortable going to the emergency room. [Resident 1] replied yes. [Caregiver C] stated [s/he] told [DO A] and [DO A] said 'right now I am not too worried about it' it was just a bloody nose and 'we could get it to stop.' [Caregiver C] stated they did ask [him/her] one other time about going to the emergency room. [Caregiver C] stated [s/he] was frustrated because [s/he] wanted [Resident 1] to go to the emergency room because [s/he] could not get it to stop. [Caregiver C] stated when it finally stopped [s/he] had the call from another resident. The call from the other resident was about 0345 hours. [Caregiver C] said when [s/he] was done helping that resident [s/he] got back to the care corner, where they do charting. [Caregiver C] stated [s/he] called [DO A] back and asked [him/her] what [s/he] needed to do. [DO A] stated to go check with [Resident 1] and see if [s/he] still wanted to go. [Caregiver C] stated [s/he] thought to [him/herself] 'why, [s/he] said twice [s/he] wanted to go', but figured [s/he] best do what [his/her] boss told [him/her] to do.	N 353		

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N 353	Continued From page 6 [Caregiver C] went to check with [Resident 1] and found [him/her] unresponsive ... I asked [Caregiver C] about calling [RN B]. [Caregiver C] stated yes, [RN B] was sleeping and [s/he] woke [him/her] up. [Caregiver C] stated [RN B] told [him/her] to put pressure and grab ice. [Caregiver C] stated [s/he] did that, but the nose bleed still was not stopping. [Caregiver C] stated [s/he] then called [RN B] again. [Caregiver C] stated when [s/he] said it was not stopping, [RN B] told [Caregiver C] to call [DO A] ..." On 07/17/2025 from approximately 10:00 a.m. - 11:00 a.m., Surveyor interviewed DO A and RN B, who was also the administrator, about the night Resident 1 had a bloody nose and died. DO A told Surveyor s/he was on the phone with Caregiver C "a good portion" of the time to assist Caregiver C with Resident 1. DO A said Resident 1 was a stubborn person, non-verbal, but could say yes or no and some swear words. DO A said Resident 1 could understand, but had a difficult time being understood. RN B said Resident 1 was a "typical" non-verbal dysphasia resident. DO A said Resident 1 did recently have his/her power of attorney for health care (HCPOA) activated due to him/her having difficulty expressing his/her needs and wants. DO A explained Resident 1 had been in and out of the hospital recently due to COPD exacerbations. RN B said Caregiver C called him/her first around 2:00 a.m. and told RN B that Resident 1 had a bloody nose. RN B said s/he told Caregiver C to put ice on his/her nose while pinching the nose and if it did not stop to send him/her in and call Resident 's HCPOA and DO A for procedure. DO A had printed screenshots of the phone calls s/he had with Caregiver C. DO A said s/he had a missed call at 2:28 a.m. DO A called back at 2:29 a.m. and did not reach him/her. DO A called again at 2:30 a.m.	N 353		

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and was on the phone for 3 minutes. DO A said Caregiver C reported that Resident 1 came out of his/her room and waved Caregiver C down to his/her room. Caregiver C said Resident 1 had been sitting on the commode as there was blood in front of the commode and feces in the commode. Resident 1 was naked at the time. DO A said Caregiver C asked Resident 1 if s/he fell and Resident 1 said no. DO A said s/he reassured Caregiver C and asked Caregiver C how Resident 1's breathing was. DO A said s/he could hear resident 1 grunting. DO A said maybe the nasal cannula caused the bloody nose. DO A said s/he was on the phone with Caregiver C again at 2:35 a.m. for 26 minutes. DO A said, "it sounded like [s/he] was able to get it stopped." DO A said Caregiver C reported Resident 1 refused to put his/her head up. DO A said Caregiver C reported Resident 1 was spitting out blood clots as his/her nose was plugged. DO A said s/he knew Resident 1 was a "private [wo/man]" and since Resident 1 was naked, DO A had Caregiver C clean Resident 1 up and then start the process to call Resident 1's HCPOA. DO A said when s/he was on the phone with Caregiver C they asked if Resident 1 wanted to go to the emergency room and DO A said s/he could hear Resident 1 say, "nah, nah." DO A said there were no concerns with Resident 1's breathing while they were on the phone. DO A said Caregiver C told him/her, s/he thought Resident 1 was stable and Resident 1 had the nasal cannula in his/her mouth. DO A said Caregiver C was able to get Resident 1 "half dressed." DO A said at 3:08 a.m., Caregiver C called DO A back and they were on the phone for approximately 24 minutes, this is when Caregiver C started to get Resident 1 dressed and Caregiver C got a call for another resident. DO A said this is when Caregiver C left Resident 1 to

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go check on the other resident. DO A said Caregiver C called DO A back at 3:43 a.m. DO A said s/he was explaining to Caregiver C to call Resident 1's HCPOA. DO A said s/he told Caregiver C to go check on Resident 1. Caregiver C went to check on Resident 1 and told DO A s/he thought Resident 1 "passed out." DO A said Caregiver C said Resident 1 let out a sigh and s/he told DO A, I believe s/he has passed away. DO A said s/he told Caregiver C to call EMS. DO A said s/he came to the facility and EMS, multiple police officers and the coroner were all present when s/he arrived. DO A said s/he called Resident 1's HCPOA when s/he arrived to the facility. Surveyor asked if that was the first time Resident 1's HCPOA was called. DO A said, "Yes." Surveyor asked DO A and RN B if Resident 1 had a history of nosebleeds. DO A said s/he did not remember Resident 1 having a nosebleed. RN B said Resident 1 was on oxygen for a long time and it was not uncommon for a person to get a nosebleed when they are on oxygen. Surveyor asked if Resident 1 was on any "blood thinners" or anti-coagulants. Both DO A and RN B told Surveyor Resident 1 was not. DO A said s/he thought maybe the nosebleed was caused from Resident 1 having a bowel movement as most of the blood was in front of the commode and there was feces in the commode.

On 07/17/2025, Surveyor reviewed Resident 1's record.
Resident 1 was admitted to the facility on 08/25/2017. His/her primary diagnosis was cerebral infarction (stroke) due to embolism (blood clot) of left middle cerebral artery. His/her other diagnoses included, in part: atrial fibrillation, acute posthemorrhagic anemia (a condition of rapid blood loss resulting in low red blood cells), aphasia (impaired ability to speak), and COPD.

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Resident 1's physician orders included, in part:
Aspirin 81 milligrams (mg) daily for cerebrovascular accident (CVA or stroke).
Clopidogrel Bisulfate (Plavix) 75 mg daily for CVA.
Administer oxygen therapy continuous 2 Liters (L) at rest and 6 L continuous with activity for shortness of breath.

The following were retrieved from the National Institute of Health. The first is regarding aspirin and Plavix increasing the risk for bleeding. The second article describes oxygen as a prescribed medication.

"The available evidence demonstrates that the use of clopidogrel plus aspirin in people at high risk of cardiovascular disease and people with established cardiovascular disease without a coronary stent is associated with a reduction in the risk of myocardial infarction and ischaemic stroke, and an increased risk of major and minor bleeding compared with aspirin alone." (Squizzato A, Bellesini M, Takeda A, Middeldorp S, Donadini MP. Clopidogrel plus aspirin versus aspirin alone for preventing cardiovascular events. Cochrane Database Syst Rev. 2017;12(12):CD005158. Published 2017 Dec 14. doi:10.1002/14651858.CD005158.pub4).

"Medical grade oxygen is classified as a drug and needs to be prescribed by a qualified healthcare professional. Oxygen therapy is prescribed to people who cannot maintain normal blood oxygen saturation while breathing atmospheric air ... Oxygen therapy is prescribed to people with medical conditions that render them unable to consume adequate oxygen through normal breathing ... A patient needs oxygen therapy

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when the measured oxygen is below a certain level (hypoxemia). This level can be measured directly from blood or indirectly by using a pulse oximeter ..." (Groenewald, L., Faber, L., Fourie, J. P., Oosthuizen, C. J., Müller, M., Van der Westhuizen, K., Kapp, D. D., Swanepoel, R., & Brits, H. (2022). Oxygen as a drug and scarce commodity: Do we use it rationally?. South African family practice : official journal of the South African Academy of Family Practice/Primary Care, 64(1), e1-e6. https://doi.org/10.4102/safp.v64i1.5544).

On 05/16/2025, Resident 1 was admitted to the hospital for a COPD exacerbation.

On 05/20/2025, Resident 1's lab work indicated Resident 1 had low red blood cells and low hemoglobin (Hgb). Resident 1's Hgb was 8.9 grams/deciliter. The normal range for Hgb is 13.2 - 16.6 grams/deciliter.

"A hemoglobin test is a blood test. It measures the amount of a protein in red blood cells called hemoglobin. Hemoglobin carries oxygen to the body's organs and tissues when you breathe in. Then it carries the waste gas carbon dioxide back to the lungs to be breathed out." (Retrieved on 07/22/2025 from: https://www.mayoclinic.org/tests-procedures/hemoglobin-test/about/pac-20385075).

On 05/21/2025, Resident 1 was discharged from the hospital, and returned back to the facility.

On 06/04/2025, Resident 1 was sent to the emergency room for shortness of breath and mucous flowing out of his/her nose.

On 06/05/2025, Resident 1 returned back to the

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	510330	A. BUILDING: _____ B. WING _____	C 07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MANOR	119 E 4TH ST N LADYSMITH, WI 54848

(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 353	Continued From page 11 facility with a diagnosis of COPD exacerbation. On 06/17/2025, Resident 1's HCPOA was activated. On 06/20/2025, Resident 1 had a bloody nose and died at the facility. On 07/17/2025, Surveyor reviewed Caregiver C's employee file. Caregiver C had his/her first and last name changed from Person H to Caregiver C. Caregiver C's date of hire was 05/05/2025. The employee roster identified Caregiver C as a non-certified caregiver. Caregiver C's training record indicated s/he was trained on the following policies for change in condition and emergency care: The provider's policy titled, Change of Condition, revised 12/05/1997, read: "POLICY: Change in condition is defined as any change in consciousness, alertness, balance, any c/o (complaints of) chest pain, deterioration in communication or cognitive abilities, any deterioration in behaviors or mood. 1. Serious illness a. Take a full set of vital signs including temperature, pulse, respirations, and blood pressure b. If diabetic do a chemstrip (blood sugar check) c. Follow emergency procedure per facility policy 2. Falls With SUSPECTED head, back, hip injuries or excessive bleeding. a. DO NOT MOVE RESIDENT b. Apply pressure per 1st aide training to stop	N 353		

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N 353	Continued From page 12 bleeding. c. Do vital signs only if time or condition allows. EXCESSIVE BLEEDING defined as observable bleeding from any body orifice, skin. Check under clothing, dressings, casts, Check for color, temperature, condition of skin, any weakness or fatigue noted." The provider's policy, titled Emergency Care, no date, read: "Procedure Title: Emergency Care Purpose: To assure adequate response to resident emergencies Policy Statement: Residents will receive appropriate emergency care and will have an emergency call pendant. Staff will be trained in first aid for early management of problems. This DOES NOT include CPR (cardiopulmonary resuscitation) or rescue breaths. Well-being checks of each resident will be made daily to ascertain whether an emergency has occurred. Prompt response to an activated call system will be provided 24 hours a day. Procedure: 1. Call 911. Give the NAME OF RESIDENT, AGE, and CONDITION. 2. Send copies with resident of: MEDICATIONS SHEETS FROM MAR (medication administration record) PHYSICIAN ORDERS FROM CHART FACE SHEET FROM CHART ADVANCE DIRECTIVES DOCUMENTS OF RESPONISBILITY 3. Call hospital ER (emergency room) and inform of resident (give name) being sent by ambulance and reasons sent. 4. Call emergency family members or guardians to inform: Phone numbers are on face sheet in	N 353		

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front of chart.
5. Give ER approximately ½ to 1 hr (hour), then call ER for information on how resident is doing and if resident [sic] to be returning to facility.
6. ER may call several times for more information, can be found in resident chart.
7. Write information on brain board and pass on to next shift.
8. Emergency procedure posted at nurse's station
...
9. Inform caseworkers of episode and if on a weekend notify caseworker ASAP (as soon as possible) next working day.
10. Call Care Team Coordinator: Phone numbers listed on facility phones if unable to contact Care Coordinator, call Administrator."

Caregiver C signed and dated 04/21/2025, a document, titled: "NOC (night shift) Tips and Guidelines" This document included the following: "Falls/Emergencies/Medications - please always call Nurse or Director if any falls, other types of emergencies happen, or if medication questions occur. We are available, no matter the hour or day - we are here to support and provide guidance for the team to be successful."

Caregiver C's training record included a "DEPARTMENT TASK/SKILL LIST" This record indicated Caregiver C was trained by Caregiver I, who was also a non-certified caregiver. This checklist included, in part: resident emergency and change in condition. The checklist also included a task on how to take a blood pressure, pulse and respirations. This task was not signed by either the trainer, Caregiver I, or the trainee, Caregiver C.

Caregiver C was not on the CBRF registry for medication administration.

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N 353	Continued From page 14 Caregiver C was not a qualified resident care staff as s/he did not successfully complete all applicable training, including how to obtain vital signs and medication administration. Oxygen is a prescribed medication. Caregiver C signed and dated, 06/20/2025, the following three statements: The first statement read: "I, [Caregiver C] was called into [Resident 1's] room for a bloody nose. It was between the hours of 2:00 and 2:30. We got the bleeding to stop. Was getting [him/her] ready to go to the hospital. [S/he] was fine when I got called away for another resident. I called my boss back so [s/he] could walk me through calling Emergency response. At about 4:08 I went to go check on [him/her] and found [him/her] leaning over on right side of recliner. I found [him/her] unresponsive, no pulse, and not breathing. I proceeded to call the ambulance/911 and I let them in and paramedics said nothing to do." The second statement read: "The last time I saw [Resident 1] alive and in stable condition was about 3:45 before I went to help another resident. When I left [him/her] - [his/her] nose had stopped bleeding, [s/he] was using his/her nasal cannula through [his/her] mouth. When I was with [him/her] I was wiping [his/her] nose and mouth trying to keep them clear from blood clots. [S/he] was refusing some cares. I got [him/her] in [his/her] recliner off the commode to make [him/her] comfortable. I gave [him/her] some water. I called [RN B] and [s/he] suggested putting pressure on lower nose to help stop the bleeding and to put some ice on it to help stop also."	N 353		

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The third statement read:
"I was with [him/her] from 2:00 to around 3:45 continuously providing constant care. Wiping [his/her] nose and mouth, and asking if [s/he] needed anything. I did ask if [s/he] had a fall and [s/he] was very adamant that [s/he] did not have a fall."

On 07/17/2025 at approximately 1:30 p.m., Surveyor interviewed Medical Examiner (ME) J on the phone. ME J told Surveyor s/he did determine the cause of death of Resident 1. ME J said the manner of death was an accident. ME J said the cause of death was hypoxemia (low levels of oxygen in the blood) due to inability to receive oxygen due to nosebleed. On oxygen due to COPD. ME J said s/he noted decedent had a nosebleed from unknown origin. Decedent was unable to put oxygen in nose or mouth to receive adequate oxygen and died when decedent was left alone.

On 07/17/2025 at approximately 1:50 p.m., Surveyor interviewed Caregiver C on the phone. Surveyor asked Caregiver C to describe the night Resident 1 died. Caregiver C told Surveyor that around 2:00 a.m., s/he was cleaning in the kitchen and s/he heard "grunting." S/he said s/he knew it was Resident 1. S/he said Resident 1 had his/her hand over his/her nose. Resident 1 sat on the commode. Caregiver C said blood was dripping everywhere. Caregiver C said s/he sat with Resident 1 from 2:00 a.m. - 3:45 a.m. S/he described having to pull blood clots out of Resident 1's nose and mouth. S/he said some of it may have been mucous. Caregiver C said Resident 1 wanted to go to the hospital so s/he called DO A for the procedure. Surveyor asked how s/he knew Resident 1 wanted to go to the hospital. Caregiver C said it wouldn't stop

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bleeding and Resident 1 was "freaking out." Caregiver C said s/he asked Resident 1 if s/he would be more comfortable going to the hospital and s/he shook his/her head yes. Surveyor asked about what time that was. Caregiver C said around 2:30 - 3:00 a.m. but was unsure of exact time. Caregiver C said s/he started caregiving January 2025 and this was the first time s/he had to call 911. Surveyor asked Caregiver C about when s/he called RN B. S/he said s/he called RN B first. Caregiver C said RN B had Caregiver C apply pressure and ice to Resident 1's nose. Caregiver C said it still would not stop bleeding and s/he called RN B back. Caregiver C said RN B told him/her to call DO A. That is when Caregiver C called DO A. Caregiver C said s/he was on the phone with DO A when Resident 1 indicated s/he wanted to go to the hospital. Caregiver C said, "[S/he] had blood everywhere, [DO A] wanted me to clen [him/her] up." Caregiver C said s/he got most of the wet blood, but s/he still had dried blood on him/her. Caregiver C said s/he used dry wipes to pull the blood clots and s/he got the blood spill kit. Caregiver C told Surveyor s/he had Resident 1 place the nasal cannula in his/her mouth, as s/he did not want it to cause more nose bleeding. Caregiver C said, DO A told Caregiver C to tip Resident 1's head back, but Resident 1 refused this. Surveyor asked if Caregiver C knew if Resident 1 was on any medications that would cause him to bleed more. Caregiver C said s/he knew Resident 1 was on a medication for mucous and that was the only medication s/he was aware of. Surveyor asked if Caregiver C was trained in medication administration. Caregiver C told Surveyor s/he was not. Surveyor asked if Caregiver C checked Resident 1's vital signs. Caregiver C said, "I did not do that. We're not supposed to get in the med (medication) cart."

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N 353	Continued From page 17 Caregiver C said, "I didn't think about doing vital signs. I just wanted to get the bleeding to stop." Surveyor asked Caregiver C if s/he was trained on how to do vital signs. Caregiver C said that when s/he first began caregiving, s/he watched videos on vital signs but was not physically trained on how to do vital signs. S/he said s/he started in May and had not gotten around to training on vital signs yet. On 07/17/2025 at approximately 2:30 p.m., Surveyor interviewed DO A. Surveyor asked why Resident 1 was not sent to the hospital when Resident 1 requested to go. DO A told Surveyor s/he was not aware Resident 1 wanted to go to the hospital. DO A said the first time Caregiver C asked Resident 1, Resident 1 "adamantly said no." DO A said Caregiver C asked Resident 1 again and DO A was unaware Resident 1 said yes. Surveyor asked about Caregiver C calling RN B twice. DO A told Surveyor Caregiver C only called RN B once. DO A called RN B and placed RN B on speaker phone. RN B told DO A s/he would check his/her phone and RN B said s/he talked to Caregiver C at 2:16 a.m. and at 2:26 a.m. At 2:26 a.m., RN B said this is when s/he told Caregiver C to put ice and pressure on Resident 1's nose. RN B said Caregiver C called again at 2:26 a.m. and s/he told Caregiver C to call Resident 1's HCPOA, DO A, and to send Resident 1 in, if Resident 1 wants to go. Surveyor asked RN B if s/he was aware Resident 1 was on aspirin and Plavix. RN B said s/he was not aware of that at 2:00 a.m. Surveyor asked if s/he was aware, would that change his/her answer to Caregiver C. RN B said s/he would have sent him "immediate(ly)." DO A said s/he was not aware Caregiver C called RN B twice. DO A told Surveyor, "The nosebleed stopped, seemed to be breathing fine." Surveyor asked DO A if s/he had	N 353		

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N 353	Continued From page 18 Caregiver C do vital signs and check Resident 1's oxygen saturation to ensure Resident 1 was "breathing fine." DO A said s/he did not have Caregiver C check Resident 1's vital signs. DO A and RN B did not follow their policies on change in condition and emergency care for excessive bleeding. EMS was not called and Resident 1's vital signs were not assessed. Resident 1's HCPOA was not called immediately to notify of Resident 1's nosebleed. EMS was not called once Resident 1 requested to go to the hospital. The provider did not have a qualified staff present in the CBRF to administer oxygen and assess vital signs. Resident 1 had a history of posthemorrhagic anemia. Resident 1 had a low Hgb one month prior to this incident. Resident 1 was on 2 medications (aspirin and Plavix) that increased his/her risk for major bleeding. Resident 1 was dependent on oxygen and his/her oxygen saturation was not assessed to ensure s/he was receiving adequate oxygenation. Resident 1 did not receive prompt and adequate treatment for a nosebleed and died of hypoxemia. Cross Reference N0397 DHS 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake	N 353		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified	N 397		

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resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure there was a qualified resident care staff present on a 24-hour basis.

Findings include:

On 07/08/2025, the Department received a complaint that alleged staff did not call an ambulance for an emergency.

The provider is licensed to care for up to 20 residents in the client groups of: advanced age and irreversible dementia/Alzheimer's disease.

Wis. Admin. Code § DHS 83.02(42) defines a qualified resident care staff as: "an employee who has successfully completed all of the applicable training and orientation under subch. IV."

On 07/17/2025, Surveyor reviewed Caregiver C's employee file.

Caregiver C had his/her first and last name

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N 397	Continued From page 20 changed from Person H to Caregiver C. Caregiver C's date of hire was 05/05/2025. The employee roster identified Caregiver C as a non-certified caregiver. Caregiver C's training record included a "DEPARTMENT TASK/SKILL LIST" This record indicated Caregiver C was trained by Caregiver I, who was also a non-certified caregiver. The checklist also included a task on how to take a blood pressure, pulse and respirations. This task was not signed by either the trainer, Caregiver I, or the trainee, Caregiver C. Caregiver C was not on the CBRF registry for medication administration. Caregiver C's training record indicated s/he was trained on the policies for change in condition, which instructed the employee to take a full set of vital signs. On 07/17/2025 at approximately 1:50 p.m., Surveyor interviewed Caregiver C on the phone. Surveyor asked if Caregiver C was trained in medication administration. Caregiver C told Surveyor s/he was not. Surveyor asked Caregiver C if s/he was trained on how to do vital signs. Caregiver C said that when s/he first began caregiving in January 2025 at his/her previous place of employment, s/he watched videos on vital signs but was not physically trained on how to do vital signs. Caregiver C said s/he started in May and had not gotten around to training on vital signs yet. On 07/17/2025 at approximately 2:30 p.m., Surveyor interviewed DO A. Surveyor explained concerns that Caregiver C was not a qualified	N 397		

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N 397	Continued From page 21 resident care staff as s/he did not receive training in medication administration and vital signs. DO A said employees can call RN B to come and administer medications if needed. DO A said s/he was not aware Caregiver C did not complete training on vital signs. On 06/20/2025, Caregiver C was working alone in the facility when Resident 1 developed a nosebleed. Resident 1 was dependent on oxygen. Caregiver C was not qualified to administer oxygen. Caregiver C did not assess Resident 1's vital signs. Resident 1 died from hypoxemia.	N 397		