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| N 000 | Initial Comments<br><br>On 09/14/2023 and 10/04/2023, Surveyors conducted a self-report review, an abbreviated survey, and 2 complaint investigations at Gardenview Inc. Additional information was gathered through 10/27/2023. As a result 7 deficiencies were identified.<br><br>Two of 2 complaints were substantiated.<br><br>Census: 15 | N 000 | | |
| N 164 | 83.12(4)(b) Reporting when law enforcement is called.<br><br>A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not report to the department any time law enforcement personnel were called to the CBRF as a result of an incident that jeopardized the health, safety, or welfare of residents or employees.<br><br>Findings include:<br><br>On 10/05/2023, Surveyor reviewed the following police reports for all police involvement at the facility address from 05/01/2023 through | N 164 | | |

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| N 164 | Continued From page 1<br>08/23/2023.<br>Law Enforcement involvement on 05/22/2023 - Report of theft of Resident 4's jewelry<br>Law Enforcement involvement on 08/15/2023 - Report of theft of Resident 5's $60<br>Law Enforcement involvement on 07/21/2023 - Report of Resident 1 not receiving his/her medications<br><br>On 10/17/2023, Surveyor reviewed department facility records and did not find written reports related to these incidents with law enforcement involvement.<br><br>On 10/20/2023 at approximately 10:20 AM, Surveyors interviewed Administrator A who verified s/he did not report these incidents to the department as required. | N 164 | | |
| N 214 | 83.15(3)(a) Administrator shall supervise daily operation<br><br>The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected.<br><br>This Rule is not met as evidenced by:<br>Based on record review, interview, and observation, the administrator did not supervise | N 214 | | |

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| N 214 | Continued From page 2 | N 214 | | |

the daily operation of the CBRF related to resident care and services, personnel, and physical plant.

Findings include:

The provider is licensed to provide services for up to 15 residents who may be of advanced age and/or have Alzheimer's/dementia.

On 10/20/2023 at approximately 1:00 PM, Surveyors conducted an exit interview with Administrator A and Licensee U and discussed findings.

As a result of Administrator A not upholding his/her responsibility as the administrator and permitting the existence of a condition of risk to the residents, 2 complaints investigated from 09/14/2023 and 10/27/2023 were substantiated and the following 6 deficiencies were identified:

DHS 83.12(4)(b) Reporting When Law Enforcement Is Called
Based on record review and interview, the provider did not report to the department any time law enforcement personnel were called to the CBRF as a result of an incident that jeopardized the health, safety, or welfare of residents or employees.

DHS 83.20(2)((a)-(d) Department Approved Training Courses
Based on interview and record review, the provider did not ensure 1 of 1 employee obtained all department approved training as required. Caregiver B did not have training in first aid and choking within 90 days after starting employment.

DHS 83.35(3)(d) Service Plans Updated Annually

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| N 214 | Continued From page 3<br><br>Or On Changes<br>Based on record review and interview, the provider did not ensure the individual service plan (ISP) was reviewed and revised upon changes in residents' needs, abilities or physical or mental condition for Resident 1.<br><br>DHS 83.43(1) Environment Safe, Clean, And Comfortable<br>Based on observation and interview, the provider did not ensure the residents' living environment was safe, clean, comfortable and homelike.<br><br>DHS 83.45(1)(d) Hazards<br>Based on observation and interview, the provider did not ensure the building was free of hazards. The facility laundry room located in the hallway with resident rooms was propped open at all times, which did not provide a fire resistive rated enclosure for the clothes dryer. The laundry room was also utilized as storage space for cleaning compounds, polishes, and other toxic substances and was left unsecured.<br><br>Wis. Stat. Ch. 50.09(1)(e) Treatment<br>Based on interview and record review, the provider did not ensure Resident 1 and Resident 2 were treated with courtesy, respect and full recognition of the residents' dignity and individuality, by all employees of the facility. | N 214 | | |
| N 239 | 83.20(2)(a)-(d) Department-approved training courses.<br><br>Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they | N 239 | | |

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| N 239 | Continued From page 4<br>contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material.<br>Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety.<br>First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking.<br>Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the provider did not ensure 1 of 1 employee obtained all department approved training as required.<br><br>Caregiver B did not have training in first aid and choking within 90 days after starting employment.<br><br>Findings include:<br><br>On 09/14/2023, Surveyor requested Caregiver B's employee records from Administrator A. Surveyor conducted a review of Caregiver B's employee records to verify compliance with the department approved training requirements and noted the following:<br><br>The record for Caregiver B, hired 05/31/2022, did | N 239 | | |

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not contain evidence of training or evidence of meeting an exemption for first aid and choking.

On 09/20/2023, Surveyor verified Caregiver B was not on the Community-Based Care and Treatment training registry for first aid and choking.

On 10/20/2023, at approximately 1:30 PM, Surveyors interviewed Administrator A. Administrator A acknowledged Caregiver B's first aid and choking training was not in Caregiver B's employee record or on the Community-Based Care and Treatment training registry for first aid and choking. Administrator A stated, "[Caregiver B] will look for it." Administrator A agreed to submit documentation to verify Caregiver B's first aid and choking training was completed.

On 10/23/2023, at approximately 12:15 PM, Surveyor made a 2nd request via email to Administrator A for documentation to verify Caregiver B's first aid and choking had been completed.

On 10/23/2023, at approximately 2:20 PM, Surveyor received an email from Administrator A that stated, "...Thursday will be the day I will send."

On 10/26/2023, at approximately 2:15 PM, Surveyor made an additional request via email to Administrator A for documentation to verify Caregiver B's first aid and choking had been completed.

On 10/26/2023, at approximately 2:30 PM, Surveyor received an email from Administrator A that stated, "I sent them to [Licensee U] for review and then forward to you [sic].

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| N 239 | Continued From page 6<br><br>On 10/27/2023, at approximately 9:45 AM, Surveyor received an email attachment from Administrator A that stated, "I was an instructor for the Red Cross and taught First Aide [sic] and choking, from the Neenah office. [Caregiver B] was in my class 12 years ago..."<br><br>On 10/27/2023, Surveyor noted 12 years prior to current year, 2023, would indicate year 2011. In 2011, all department-approved training was required to be entered on the Community-Based Care and Treatment training registry. Surveyor reviewed the Community-Based Care and Treatment training registry and noted Caregiver B's first aid and choking training was not found. Administrator A did not provide verification Caregiver B received first aid and choking training as required. | N 239 | | |
| N 389 | 83.35(3)(d) Service plans updated annually or on changes<br><br>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. | N 389 | | |

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| N 389 | Continued From page 7<br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure the individual service plan (ISP) was reviewed and revised upon changes in residents' needs, abilities or physical or mental condition for Resident 1.<br><br>Findings include:<br><br>On 08/04/2023 and 09/06/2023, the department received complaints that alleged the provider did not provide proper care.<br><br>On 09/14/2023, at approximately 9:30 AM, Surveyor reviewed Resident 1's records and noted the following:<br><br>Resident 1 was admitted on 06/20/2022. His/her admission agreement was signed by Administrator A and Resident 1 on 06/20/2022. The admission agreement, under Section 3: Individualized Service Plan indicated, "...The Individual Service Plan addresses the physical and mental needs of each resident..."<br><br>INDIVIDUAL SERVICE PLAN (ISP)<br><br>Resident 1's Assisted Living Resident Evaluation & Level of Care: Admission/Assessment (facility ISP), had an effective date of 06/20/2022 and indicated the following:<br><br>"Falls:<br>Has no history of falls, or no falls in past 6 months.<br><br>Behaviors:<br>Behavior/Awareness: No impairments.<br>Has a behavior problem: (Not checked)<br>Agitated-hyperactive, anxious, fluctuates | N 389 | | |

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emotionally: (Not checked)
Aggressive-threatens, uses foul language, belligerent, destructive: (Not checked)
Hallucinations/Delusions-altered perception of reality: (Not checked)
Impaired judgement-unable to weigh advise: (Not checked)

Social History/Lifestyle:
Uses alcohol: Never

Mood and Behavior Concern:
Angry: No.
Aggressive: No.
Resistive: No.
Disorganized: No.

Skin:
Relevant History: None
Skin Care: Resident has no skin breakdown or wounds.
Healing Wounds/Pressure Ulcer: Resident has no healing wounds or pressure ulcers."

PROGRESS NOTES

On 09/14/2023, Surveyor reviewed Resident 1's Progress Notes:
"07/19/2023: Behaviors continues to escalate..Staff very concerned with this escalation as [s/he] normally is calm and pleasant.
07/19/2023: Call placed to [Nurse G] regarding increased behaviors.
07/20/2023: Ataff [sic] reports another resident said this resident called [him/her] and told [him/her] to go outside so they could fight.
07/20/2023: On arrival resident was very agitated. Resident told staff [s/he] had become very dizzy... [S/he] stated [his/her] thoughts are mixed up and confused...

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07/23/2023: Resident was very agitated on arrival...
07/31/2023: ... Resident is becoming verbally aggressive... Resident needed to use a wheelchair for transfers as [s/he] stated [s/he] couldn't walk on [his/her] own.
08/01/2023: ... Resident very angry and delusional...
08/02/2023: ... Resident was screamingat [sic] the officer and staff...throwing insults at staff...
08/02/2023: ...Resident started to cry and related [s/he] was panicing [sic] and didn't know how to stop. Relates [s/he] is afraid to go to sleep for fear [s/he] won't wake up...
08/07/2023: Resident is again delusional... Resident's [son/daughter] called writer to discuss [his/her] latest delusions...
08/08/2023: ...[Resident 1] called cab at 1130 [sic] to try to go to gas station to get more beer...
08/09/2023: Very delusional...
08/18/2023: ...[Resident 1] was peeing in a can outside and being rude...

DOCUMENTED CORRESPONDENCE:

On 07/19/2023, Registered Nurse (RN W) documented per Administrator A's telephone call, "[Resident 1's] change in behavior noted per nursing:
Rapid speech
Flight of ideas
Per nursing, patient is normally calm."

On 07/21/2023, RN N documented per Caregiver F's telephone call, "[Resident 1's] behavioral issues started 4-7 days ago... Unable to monitor while outside due to staffing limitations... [S/he] does not look good, this is not [him/her] at all, [s/he] used to be calm and quiet... No other falls or injuries noted that could have precipitated

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behavioral change."

On 07/21/2023, RN W documented per Caregiver X's telephone call, "Staff did call the police..." RN G responded, "... Continue to discuss with patient going to ER (emergency room) to be checked out because this is unusual behavior for [him/her]..."

On 08/21/2023, Physician Assistant (PA Y) documented per Administrator A's telephone call, "... [Resident 1] is chain smoking outside and urinating in a can outside... [S/he] has been accusing [Family Member C] of stealing from [him/her] and the staff members of raping [him/her]. This appears to be a continuation of [his/her] manic episode..."

THEDACARE DISCHARGE SUMMARY:

Hospital admission documentation dated 07/23/2023 stated, "... Difficulty walking distances. Dizziness when turning [his/her] head, and weakness in [his/her] legs."

PHYSICIANS ORDERS:

Physician S's physician's order for Resident 1 dated 08/03/2023 stated, "Orders: Fluid restriction 1.5 L/day."

Nurse G's order for Resident 1 dated 08/04/2023 stated, "SODIUM CHLORIDE 1000 MG TABLET. TAKE 1 TABLET BY MOUTH TWICE DAILY (HYPONATREMIA)."

Nurse G's order for Resident 1 dated 08/10/2023 stated, "Oxygen 1-4 L/min to keep 02 sats [sic] greater than 88%."

On 08/11/2023, Resident 1 was admitted to

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Thedacare Regional Medical Center. Resident 1 was discharged on 08/13/2023, with physician's orders, "Order For [sic] O2 (oxygen) Is [sic]: O2 at 0 L/ Min at Rest Via Nasal Cannula. O2 at 1 L/ Min with Activity via Nasal Cannula."

On 08/17/2023, Nurse G's order for Resident 1 stated, "NICOTINE 21 MG / 24HR [sic] PATCH. PLACE 1 PATCHTOPICALLY [sic] ONTO SKIN DAILY (NICOTINE ADDITION) *REMOVE EXISTING PATCH*"

FALL ASSESSMENT:

On 09/14/2023, Surveyor reviewed Resident 1's fall assessment, dated, 08/13/2023, and noted: "Mental Status: Mental Status measures the resident's self-assessment of [his/her] own ability to ambulate. Ask the resident, 'Are you able to go to the bathroom alone, or do you need assistance?' Does the resident's response to the above indicate they know the limits of their abilities to ambulate safely?" The answer selected stated, "Overestimates or forgets limits."

ADMINISTRATOR A's CHARTING:

Administrator A documented the following:
On 07/17/2023, "... Staff concerned with escalation of behavior As [sic] this is totally out of character for [him/her]."
On 07/19/2023, "... REsponded [sic] with very angry Comments [sic] to staff and residents alike."
On 07/31/2023, "Very verbally aggressive with staff and other residents [sic] Demanding other residents go out and fight..."
On 07/31/2023, "Needed help to [his/her] room as [s/he] couldn't find it."

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| N 389 | Continued From page 12<br>On 08/01/2023, "Verbally abusive to staff during noon."<br>On 08/06/2023, "Legs very edematis and couldn't get pants off."<br>On 08/07/2023, "...[Son/daughter] called was Worried [sic] staff member would be fired for [his/her] [parent's] delusions."<br>On 08/09/2023, "Very delusional..."<br>On 08/08/2023, "Up all night"<br>On 08/08/2023, "Called a cab at 11:30pm [sic] to go to get more beer."<br>On 08/15/2023, "... drinking a beer... Needed assist of 2 staff to return to building as legs Gave [sic] out..."<br>On 08/17/2023, "Requested staff help [him/her] ambulate... so [s/he] Could [sic] go out for a dinner date at 8:30 am[sic]."<br>On 08/18/2023, "...peeing in a can Outside [sic]."<br>On 08/08/2023, "... Very delusional."<br>On 08/22/2023, "... [S/he] demanded assistance to [his/her] room and staff took [him/her] in a w/c [sic]..."<br><br>On 09/14/2023, Surveyor reviewed Resident 1's records and facility's documentation and noted staff began reporting changes in Resident 1's needs, abilities or physical or mental condition on, 07/17/2023.<br><br>STAFF INTERVIEWS:<br><br>On 09/14/2023, at approximately 8:40 AM, Administrator A stated, "[Resident 1] went off the deep end in June and picking fights. [S/he] was kind, gentle, and previously would help around the facility... behaviors increased... [Resident 1] was acting out." Administrator A also stated, "[Resident 1] used to listen to me but towards the end, [s/he] couldn't care less... [S/he] threw [himself/herself] on the floor..." | N 389 | | |

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| N 389 | Continued From page 13<br><br>On 09/14/2023, at approximately 10:00 AM, Caregiver B stated, "[Resident 1] was changing. [S/he] used to be the sweetest, kindest [wo/man], then erratic talking about non-sense... [S/he] had falls. [S/he] threw [himself/herself] to the ground.... [S/he] would get angry... [S/he] would make a scene... [S/he] started speaking erratically, craziness..."<br><br>On 09/14/2023, at approximately 2:10 PM, Caregiver F stated, "[Resident 1's] attitude started to change. [S/he] started saying mean things. Towards the end of July, [s/he] changed... [Resident 1] declined rapidly... [Resident 1] was the nicest [man/woman]. So sweet and quiet..."<br><br>On 09/14/2023, at approximately 2:45 PM, Caregiver Q stated, "At the end of July or the beginning of August, [Resident 1] started changing behaviors... [S/he] started utilizing a wheelchair... [Resident 1] was in the bathroom and asked for assistance..."<br><br>On 09/21/2023, at approximately 2:00 PM, Caregiver P stated, via telephone, "I have been working here since July, and that's when [Resident 1] started declining and changing physically."<br><br>RESIDENTS INTERVIEW:<br><br>On 10/04/2023, at approximately 9:00 AM, Resident 2 stated, [Resident 1] "was a cool [wo/man] at first. All of a sudden, I don't know what happened..."<br><br>On 09/14/2023, Surveyor reviewed Resident 1's ISP. Resident 1's ISP was updated on | N 389 | | |

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| N 389 | Continued From page 14<br>08/13/2023. Resident 1's ISP did not include any detailed instructions or interventions to direct staff on what to look for regarding Resident 1's specific behaviors, changing needs, abilities or physical or mental condition.<br><br>On 10/20/2023, at approximately 1:00 PM, Surveyor shared the above information with Administrator A, Administrator T, and Licensee U and noted the multiple changes required review and should have been updated within Resident 1's ISP.<br><br>Administrator A stated, "[S/he] changed so quickly, how were we supposed to update [his/her] care plan?"<br><br>Cross Reference:<br>N0431 DHS 83.38(1)(g) Health Monitoring | N 389 | | |
| N 481 | 83.43(1) Environment safe, clean, and comfortable<br><br>Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure the residents' living environment was safe, clean, comfortable and homelike.<br><br>Findings include: | N 481 | | |

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| N 481 | Continued From page 15<br>The provider is licensed to provide services for up to 15 residents who may be of advanced age and/or have Alzheimer's/dementia.<br><br>On 06/27/2023 at approximately 9:24 AM, Surveyors, Regional Director O, and Administrator A toured the facility and observed the following:<br>-Surveyors observed a 25 plus foot hose that was unwound on the ground of the back patio. The hose spanned approximately 5 feet of space and obstructed the pathway directly in front of the back exit door. Administrator A stated the door was identified as an emergency exit. The facility's exit diagram also identified the back exit door as a primary emergency exit. Surveyor inquired about the hose located across the sidewalk and noted to Administrator A the hose was a tripping hazard. Administrator A stated, "[Resident 3] had been out watering the garden," and staff would pick up the hose. At approximately 11:00 AM, Surveyor exited the back door and inadvertently tripped over the hose. Surveyors noted the hose was still located on the ground, unwound in front of the exit, stretched across the sidewalk. At 4:00 PM, Surveyors exited through the back door of the facility to leave. Surveyors noted the hose remained on the pathway, unmoved and in the same formation it had been in the morning. The hose continued to obstruct the pathway to and from the exit door. Note: Throughout the day, residents were observed using the back exit as a means to access the safe smoking area, located on the back patio.<br>-Surveyor observed the front enclosed vestibule separated by a lentil and inside door did not contain a smoke detector. Surveyor noted the vestibule contained a table and ample standing area. | N 481 | | |

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| N 481 | Continued From page 16<br><br>-At approximately 9:26 AM, Surveyor observed water temperature in residents' common shower room to be 118 degrees Fahrenheit.<br>-At approximately 9:30 AM, Regional Director O observed the standing hot water tank located in the right resident hall mechanical room was 120 degrees Fahrenheit. Administrator A verified awareness of the tank needing to be at least 140 degrees Fahrenheit to prevent the growth of bacteria and legionella's disease.<br><br>On 10/04/2023 at approximately 10:18 AM, Surveyors toured the facility and noted the following:<br>-Surveyor observed water temperature in residents' common shower room to be 119.4 degrees Fahrenheit.<br>-Surveyor observed exit diagrams were not posted where residents could see them in a conspicuous place.<br>-Surveyors observed 2 hoyer lifts located at the common area at the front entrance, parked in front of the activity closet.<br><br>On 10/20/2023 at approximately 1:00 PM, Surveyors interviewed Administrator A who acknowledged the listed concerns with the facility's physical environment and that s/he would follow up.<br><br>Cross Reference:<br>N0495 DHS 83.45(1)(d) Hazards | N 481 | | |
| N 495 | 83.45(1)(d) Hazards.<br><br>Hazards. The CBRF shall maintain each building in good repair and free of hazards.<br><br>This Rule is not met as evidenced by: | N 495 | | |

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| N 495 | Continued From page 17<br><br>Based on observation and interview, the provider did not ensure the building was free of hazards. The facility laundry room located in the hallway with resident rooms was propped open at all times, which did not provide a fire resistive rated enclosure for the clothes dryer. The laundry room was also utilized as storage space for cleaning compounds, polishes, and other toxic substances and was left unsecured.<br><br>Findings include:<br><br>The provider is licensed to provide services for up to 15 residents who may be of advanced age and/or have Alzheimer's/dementia.<br><br>On 06/27/2023 at approximately 9:24 AM, Surveyors and Administrator A toured the facility. Surveyor noted the building had two resident hallways. The hallway to the right of the entrance contained a laundry room located directly across and down the hall from resident rooms. Surveyors observed the door to be propped open by a door stop. Surveyor noted the washer and dryer were running at the time of the tour.<br><br>On 06/27/2023 at approximately 3:00 PM, Surveyor observed the laundry room to remain open and the dryer to be running.<br><br>On 10/04/2023 at approximately 8:50 AM, Surveyor toured the facility again and noted the laundry room to be open. Surveyor observed the laundry room and the hallway directly outside the entrance to be warm feeling in temperature. While in the laundry room, Surveyor observed the following substances-<br>On the washing machine:<br>-1 jug of laundry detergent<br>-1 spray bottle of Clorox urine remover | N 495 | | |

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| N 495 | Continued From page 18<br><br>In unlocked cupboards with labels of chemicals on the cupboards:<br>-12 bottles of North Woods shower foam (acid cleaner, disinfectant, virucide, deodorizer, soil tolerance)<br>-9 cans of shine-up furniture polish<br>-6 bottles of Clorox urine remover<br>-1 bottle of Murphy furniture polish<br>-1 spray bottle of grout cleaner<br>-1 jug of laundry detergent<br>-1 spray bottle of stain remover<br>-10 bottles of Oxivir Tb (liquid disinfectant cleaner)<br>-12 bottles of toilet bowl cleaner<br>-3 bottles of Deep clean liquid crème cleanser<br>-3 bottles of live Liquid bacteria<br>-4 bottles of floor cleaner<br>-12 spray cans of spray disinfectant<br>On the floor:<br>-1 open drum of unlabeled laundry detergent; 1 unopened drum of laundry detergent<br><br>On 10/04/2023 at approximately 8:53 AM, Surveyor interviewed Caregiver F who stated the laundry room was always left open. Administrator A joined the conversation and stated the door does close and lock, but they left it open "because we don't have anyone who will you know," and gestured a drinking motion in reference to drinking the toxic substances.<br><br>On 10/20/2023 at approximately 1:00 PM, Surveyors interviewed Administrator A who verified the laundry room was left propped open and unlocked, and contained toxic substances.<br><br>Cross Reference:<br>DHS 83.43(1) Environment Safe, Clean, And Comfortable | N 495 | | |

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| Y3234 | 50.09(1)(e) Treatment<br><br>(1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to:<br><br>(e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the provider did not ensure Resident 1 and Resident 2 were treated with courtesy, respect and full recognition of the residents' dignity and individuality, by all employees of the facility.<br><br>Findings include:<br>On 08/24/2023 and 09/06/2023, the department received 2 complaints that alleged residents were being mistreated and verbally assaulted.<br><br>RESIDENT 1:<br>On 09/14/2023, Surveyor requested to review Resident 1's records and noted the following:<br>Resident 1's date of admission was on, 06/20/2022, with diagnosis that included:<br>Unspecified severe protein-calorie malnutrition, major depressive disorder, single episode, mild, | Y3234 | | |

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adjustment disorder with mixed anxiety and depressed mood, insomnia, unspecified, essential (primary) hypertension, and chronic obstructive pulmonary disease, unspecified.

Resident 's diagnoses were updated on 12/26/2022, to include: "Hyponatremia."

INDIVIDUALIZED SERVICE PLAN (ISP):
Resident 1's ISP, updated on 08/13/2023, included the following:
"Focus: Has memory loss/dementia r/t [sic] (related to) Delusional Behaviors [sic], disease process medically induced encephalopathy." (Encephalopathy means damage or disease that affects the brain. It happens when there's been a change in the way your brain works or a change in your body that affects your brain. Those changes lead to an altered mental state, leaving you confused and not acting like you usually do ...Symptoms: the symptoms you have depend on the type and cause of your encephalopathy, but some of the most common ones are: confusion, memory loss, personality changes, and trouble thinking clearly or focusing) (Source: Brain & Nervous System, What is Encephalopathy, October 24, 2023, https://www.webmd.com/brain/what-is-encephalopathy (retrieval date - October 25, 2023).)

PROGRESS NOTES:
On 07/28/2023, Caregiver B documented, "When [sic] going in to make bed resident told writer that I crossed the line calling [his/her] [son/daughter] about [his/her] previous behaviors and next time to come to [him/her] like a [wo/man]. writer [sic] told [him/her] they crossed no lines but they're not going into it with [him/her]."

On 07/29/2023, Administrator A documented,

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"[Resident 1] went to see writer. States [s/he's] been sexually flirted with by a staff member. Due to [his/her] recent exagerations [sic], writer contacted employee who denied any type of interaction with resident."

On 08/01/2023, Caregiver D documented, "... [Resident 1] very angry and delusional at this point. Making up far fetch [sic] unrealistic stories ..."

On 08/01/2023, Administrator A documented, "Received first telephone call from staff regarding this [Resident 1] who was demanding oxygen as [s/he] 'couldn't breathe.' O2 sat at 97% on room air. Was just outside smoking ..." (Oxygen saturation is a measure of how much hemoglobin, the protein contained in red blood cells that is responsible for delivery of oxygen to the tissues, is currently bound to oxygen compared to how much hemoglobin remains unbound) (Source: News Medical Life Sciences, What is Oxygen Saturation, February 25, 2021, https://www.news-medicat.net/health/What-is-Oxygen-Saturation.aspx (retrieval date - October 25, 2023).)

On 08/02/2023, Administrator A documented, "Received another telephone call from staff regarding [Resident 1] who again was demanding oxygen. Again [sic] O2 sat 95% room air ...Again [sic] just came in from smoking ...[Resident 1] now stating [s/he] couldn't walk due to [his/her] breathing when in fact [s/he] had walked in from outside to the dining room."

On 08/02/2023, Administrator A documented, "Received another telephone call from staff as [Resident 1] was on the telephone with 911 demanding a police officer come immediately as

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staff was 'not listening to me.' ...An officer did respond but refused to talk with writer. [Resident 1] again demanded oxygen and the officer attempted to tell staff to give it to [him/her] ... [Resident 1] was screamingat [sic] the officer and staff. Told officer to arrest staff for 'abuse.' [Resident 1] then took officer to [his/her] room to talk. Officer came out of room and told staff to administer an inhaler to [Resident 1]. Writer ok'd use of Albuterol inhaler ...[Resident 1] remained in is [sic] room for a short while and then came out to dining room ... Staff continued to answer call lights and do [his/her] job and ignored this resident."

On 08/02/2023, Administrator A documented, "[Resident 1] came to see writer about staff. Writer related [s/he] needed to stop [his/her] constant antagonizing of staff. [Resident 1] started to cry and related [s/he] was panicking and didn't know how to stop. Relates [s/he] is afraid to go to sleep for fear [s/he] won't wake up ..."

On 08/08/2023, Caregiver H documented, "[Resident 1] was awake all noc shift. went [sic] to bed at 515am [sic]. was out talking to writer babbling on about previous instances ..."

On 08/09/2023, Administrator A documented: "Very delusional ...bizarre episode with staff ..." Resident 1 does not have a mental health diagnosis and has not experienced delusions previously.

On 08/12/2023, Administrator A documented, "Hospital RN called and asked if [Resident 1] could return late tonight. Writer explained the difficulty in obtaining medication orders late at night... Writer asked RN to tell [him/her]

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| Y3234 | Continued From page 23<br><br>Gardenview could not take [him/her] back until tomorrow morning ...About 15 minutes later [Resident 1] called writer to say [s/he] was returning tonight, and writer told [him/her] that was not possible for various reasons. [Resident 1] seemed to accept this but then kept calling the building every 10 minutes to talk to writer. After 5 calls, writer ignored [his/her] telephone calls."<br><br>On 08/17/2023, Administrator A documented, "[Resident 1] called to demand staff bring [him/her] [his/her] meds. Staff was busy and told resident to come and eat breakfast and get meds when staff was available."<br><br>On 08/18/2023, Caregiver I documented, "[Resident 1] asked Agency [sic] staff member to perform [his/her] peri care wash up. Staff suggested [Resident 1] perform this on [his/her] own several times ..."<br><br>On 08/21/2023, Caregiver B documented, "[Resident 1] at dinner time kept demanding [s/he] needed [his/her] oxygen. Writer told [him/her] since [s/he] wasn't eating [s/he] can get up and go to [his/her] room and get it. [S/he] started yelling and telling staff [s/he] was going to have a job if it's the last breathe [sic] [s/he] takes. Writer then called supervisor who agreed that [Resident 1] can get up and go get it ..."<br><br>On 08/22/2023, Administrator A documented, "Writer had talked with [Resident 1] on the telephone and told [him/her] to either stop [his/her] ranting and raving in the dining room where [s/he] was disturbing others, or [s/he] could go to [his/her] room ..."<br><br>FOX CROSSING POLICE DEPARTMENT NOTES: | Y3234 | | |

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| Y3234 | Continued From page 24<br><br>On 09/14/2023, Surveyor requested Resident 1's records from the Outagamie County Police Department. Surveyor received an email with attached records from the Police Department on, 09/18/2023. On 09/18/2023, Surveyor reviewed records and noted the following:<br>On 08/21/2023, Officer J documented, "... [Administrator A] believes [Resident 1] is off [his/her] rocker ..."<br><br>COMMUNITY CARE NOTES:<br>On 09/19/2023, Surveyor reviewed records and noted the following:<br>On 08/01/2023, Registered Nurse K (RN K) documented, "[Resident 1] became angry and noted that staff just don't want to help [him/her] with anything and [s/he] finally got a back bone [sic] and is standing up for [himself/herself]."<br><br>On 08/24/2023, Care Manager L (CM L), documented, " ...Family Member C (FM C) also relayed that [his/her] [brother/sister], [Family Member M (FM M)] had an adverse experience when [s/he] returned to Gardenview Assisted Living to ensure that [his/her] [mother/father's] room was locked. [FM C] relayed that a staff member made comments in front of [FM M] to the effect that [s/he] doesn't believe [Resident 1] will 'make it' and that should [s/he] return to Gardenview, [s/he] will not provide care for [him/her] due to [his/her] recent behaviors.<br><br>DOCUMENTED CORRESPONDENCE:<br>On 09/19/2023, Surveyor reviewed facility's records and noted the following:<br>On 08/21/2023, RN N documented per Administrator A, [Resident 1] "is currently outside peeing in a can because [s/he] is too lazy to come back in ..." | Y3234 | | |

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FACILITY'S DOCUMENTATION:
On 09/21/2023, Surveyor reviewed facility's records and noted the following:
Administrator A documented: Verbal Warning #1 (Undated) to Caregiver B:
"[Caregiver B] was in the dining room and loudly stated that a resident who was sent to the ER should 'die' and that [s/he] would be better off 'dead.' A family member heard this and was very upset.
[Caregiver B] stated [s/he] was frustrated with this resident because [s/he] accused [him/her] first of sexual assault. ... I related I understood how [s/he] felt but that [s/he] needed to be careful what [s/he] said out loud no matter what. We discussed our Core Values again.
[Caregiver B] will apologize to the family when they are next here."

ADULT PROTECTIVE SERVICES NOTES:
On 09/21/2023, Surveyor reviewed records and noted the following:
On 08/28/2023, Social Worker O (SW O), documented conversations with Caregiver F, Caregiver B, and Administrator A.
On-site conversation with Caregiver F:
"Writer arrived and was approached by staff, [Caregiver F], who immediately told writer there are concerns with another care taker [sic], [Caregiver B]. [Caregiver F] stated [Caregiver B] should not be allowed to work in a care facility."

On-site conversation with Caregiver B:
"Writer had an opportunity to speak with [Caregiver B] (before [s/he] left - it was after [his/her] shift). [Caregiver B] stated last Monday [s/he] charted [Resident 1] getting up from [his/her] chair in the dining room area and was told to go to [his/her] bedroom to get [his/her] oxygen. [Caregiver B] stated when they walked

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around to the living room area, [Resident 1], 'threw [himself/herself] to the floor' and stated [s/he] didn't need help. [Caregiver B] attempted to get [Resident 1] up off the ground but [Resident 1] refused to allow [him/her] to help, so two other staff members assisted and lifted [Resident 1] up. Writer asked about [Resident 1's] oxygen use. [Caregiver B] stated [Resident 1] was able to move around the facility with no problems and not in distress. [Resident 1] would walk out of [his/her] room and into the dining room then ask for [his/her] oxygen. [Caregiver B] stated they would tell [Resident 1] to go back to [his/her] room to use [his/her] O2 [sic]. Writer questioned why [s/he] would be instructed to go back to [his/her] room to use [his/her] O2 if [s/he] is requesting it in a different room. [Caregiver B] stated [s/he] was walking around 'just fine' and [s/he] was not distress [sic], so [s/he] could make it back to [his/her] room. [Caregiver B] then stated [s/he] didn't realize [Resident 1] was suppose [sic] to be on continuous O2; but [s/he] would not wear it."

On-site conversation with Administrator A:
"When asked about all the reports of sexual assault, [Administrator A] stated [s/he] only looked into two of them and documented them as the story was the same and [Resident 1] would only change the name of the employee. [Administrator A] stated [s/he] didn't think [s/he] needed to as [s/he] knew [Resident 1] was trying to get an employee of [his/hers] in trouble and was making all of it up ... After [Resident 1] was found unresponsive and brought to the ED (Emergency Department); they went through [his/her] room ...

NOTE POSTED ON PANTRY DOOR:
On 09/14/2023, Caregiver F showed Surveyor a

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photo taken with a cell phone and stated, "Administrator posted a note on the food pantry door." Surveyor observed the photo and noted a piece of white paper that included the following words:

"UNDER NO CIRCUMSTANCES DO WE LEAVE ANY MEDICATION WITH A RESIDENT TO TAKE LATER. [RESIDENT 1] HAD AN INTENTIONAL OVERDOSE LAST PM [sic] PROBABLY WITH TRAZODONE!!! [sic] YOU CHART YOU WATCHED THE RESIDENT TAKE THEIR MEDS WHEN YOU CHECK 'YES.'" Surveyor also noted 4 white, unidentified pills, taped to the bottom of the note.

On 09/14/2023, Surveyor interviewed Administrator A. Administrator A did not respond.

STAFF REPORT:
On 09/19/2023, at approximately 6:00 AM, Surveyor received written documentation from Caregiver F that stated, " ...[Resident 1] would still be alive if [Caregiver B] who was taking care of [him/her], would not have sworn at [him/her], walked away from [him/her] while not giving [him/her] [his/her] needed oxygen. Because [s/he] didn't have [his/her] needed oxygen, [s/he] was rushed to the hospital, fell into a coma and passed away on Sept 5th, 2023. [sic] ...[Resident 1] was abused or threatened to be abused by [Administrator A] in front of the Menasha Police Officer and other caregivers ...it was something like, 'I want to punch [him/her] right in the face.'"

RESIDENTS INTERVIEWS:
Resident 3:
On 09/14/2023, at approximately 2:20 PM, Surveyor interviewed Resident 3. Resident 3 stated, "[Resident 1] sat outside for over an hour

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with a pee puddle underneath [him/her]. It went through the chair and onto the ground. [Resident 1] told me, 'I can't get anyone to help me,' and said [his/her] feet were cold. I told [Caregiver B]. [Caregiver B] did the only thing [s/he] ever does, called [Administrator A]. [Administrator A] said, 'If [Resident 1] was able to go out to smoke, [s/he's] able to get in.' It's wrong ...[Resident 1's] breathing was shot ... Definitely some neglect there. I know what happened, I'm not dumb. I'm not a stupid [wo/man] ... [Resident 1] wasn't feeling good. You lash out when you don't feel good. [Resident 1] apologized for [his/her] behaviors. Resident 3 began crying and stated, "I've seen lots of things going on, no matter what [s/he] says, they're professionals. [Resident 1] was asking for [his/her] oxygen in the dining room and was told if [s/he] was well enough to get to the dining room, [s/he's] well enough to get [his/her] oxygen. [S/he] asked quite a few times. [Caregiver B] was told by [Administrator A] again, [s/he's] good enough to get it [himself/herself]. ... They treated [him/her] as a person faking it, [s/he] wasn't faking it. Something was wrong." Resident 3 was in tears and stated, "[Resident 1] deserved better."

Resident 2:
On 10/04/2023, at approximately 9:00 AM, Surveyor interviewed Resident 2. Resident 2 stated, "[Resident 1] fell and couldn't get up, but [Caregiver B] should've helped [him/her] get in [his/her] wheelchair, but [s/he] didn't. [S/he] said, 'If you can walk out here, you can walk back to your room.'"

STAFF INTERVIEWS:
Administrator A:
On 09/14/2023, at approximately 9:00 AM, Surveyor interviewed Administrator A.

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| Y3234 | Continued From page 29<br><br>Administrator A stated, "Everyone was good with [Resident 1], except [Caregiver B]. [Caregiver B] did make inappropriate comments, 'Thank God [s/he] went to the hospital, I hope [s/he] dies ...You need to go to your room.' ... [Caregiver B] would yell back at [him/her], 'knock it off' ...I would have to tell [Caregiver B] to walk away."<br><br>Caregiver B:<br>On 09/14/2023, at approximately 10:00 AM, Surveyor interviewed Caregiver B. Caregiver B stated, "[Resident 1] made up a lot of lies. [S/he] would seek attention, asking for things [s/he] can't have ...I can usually tell when someone can't breathe. [Resident 1] would sit there and demand things like oxygen." Caregiver B stated a lot of it was behaviors so s/he didn't feel s/he needed to get Resident 1 oxygen. Caregiver B acknowledged Resident 1, "had critically low sodium symptoms." Caregiver B stated Resident 1 would erratically talk, then stated, "I don't remember any examples."<br><br>Caregiver F:<br>On 09/14/2023, at approximately 2:10 PM, Surveyor interviewed Caregiver F. Caregiver F stated at the end of June, Caregiver B was reported to [Administrator A] but, "[Administrator A] hasn't done anything ...They both were nasty to [Resident 1] ...They would both scream at [him/her]. [Resident 1] never talked suicidal ... [Resident 1's] [son/daughter] overheard [Caregiver B] saying bad things ...[Resident 1] asked for assistance one day to get help and [Caregiver B] said no ...[Resident 1] reported [s/he] had a fall and hit [his/her] head in mid-July and [Administrator A] and [Caregiver B] didn't send [him/her] out because they said they didn't believe [him/her]." | Y3234 | | |

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| Y3234 | Continued From page 30<br><br>Caregiver Q:<br>On 09/14/2023, at approximately 2:24 PM, Surveyor interviewed Caregiver Q. Caregiver Q stated, "[Caregiver B] would argue with [Resident 1]. Whatever [s/he] said, [s/he] would have to argue with [him/her]. [Resident 1] asked for [his/her] oxygen. [Caregiver B] said, 'If you can go out to smoke, you can get your own oxygen.' ... [Caregiver B] didn't like [Resident 1] to use a wheelchair. [S/he] would yell at [him/her]. [S/he] would swear at [him/her]. I witnessed it. I'm not aware of any physical abuse. I only saw verbal. One time, [Resident 1] was in the bathroom and asked for assistance. [Caregiver B] told [him/her] that [Administrator A] said [s/he] doesn't need help ... I've gone to [Administrator A] about [Caregiver B's] mouth, attitude, and verbally abusing residents ... [Resident 1] was denied assistance multiple times. [Resident 1] sat in [his/her] urine for about an hour," because Caregiver B refused to assist him/her.<br><br>Caregiver P:<br>On 09/21/2023, at approximately 2:00 PM, Surveyor interviewed Caregiver P, via telephone. Caregiver P stated, "I witnessed [Caregiver B] not giving [Resident 1] [his/her] oxygen, yelling at [him/her], and being mean ...it was an everyday thing... [Resident 1] was in the dining room and said [s/he] needed [his/her] oxygen, which was in [his/her] room. [Caregiver B] denied getting it for [him/her] after [Administrator A] said [s/he] can get it [himself/herself] if [s/he] needs it. [Resident 1] wanted the oxygen brought to [him/her] so [s/he] didn't have to walk to get it. [S/he] seemed short of breath."<br><br>Caregiver P stated, "[Resident 1] was outside and [s/he] had urinated on [himself/herself] because [s/he] couldn't get up. [Caregiver B] told [him/her], | Y3234 | | |

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'no' and called [Administrator A] who told [Caregiver B] not to help [him/her] because, 'If [s/he] can go out there by [himself/herself], then [s/he] can get inside by [himself/herself]. [S/he's] just looking for attention.' I was told to bring [him/her] in and change [his/her] clothes. [Administrator A] came in then said, 'I felt like hitting [Resident 1] but the cop told me don't do it because it makes things worse.' [Administrator A] said this in the lobby and there were 2 other staff members there from the temp [sic] agency that heard [him/her]. [S/he] said it very clearly ..."

"Caregiver P stated, "[Resident 1] had fallen, lost [his/her] balance, and fell in the dining room when [s/he] was asking [Caregiver B] to bring [him/her] oxygen and [Caregiver B] kept saying, 'No' very loudly, which amped [Resident 1] up more. [Caregiver B] said, 'If you can go out and smoke, you can go get your own oxygen.' [S/he] kept antagonizing [him/her] ... [Caregiver B] always talks rough with all the residents. I would tell [him/her], 'That's not how you talk to residents ...' [S/he] is very loud, very obnoxious, and not professional at all. I feel bad for the residents."

INTERVIEW WITH FAMILY MEMBER C:
Family Member C stated the following, on 10/01/2023, at approximately 10:20 AM, via email to Surveyor:
"[Administrator A] would often sound and act exasperated when talking about [Resident 1] in the last month of [his/her] life, though I only personally talked to [him/her] a few times. Things like, 'I don't know what to do with [him/her].' [S/he] often spoke as if [s/he] had schizophrenia or dementia ...My [parent] was very unhappy at the facility and wanted leave [sic] every day. I had no idea why at the time, but I believe [Administrator A] and [Caregiver B] contributed to the situation ...

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| Y3234 | Continued From page 32<br><br>[Resident 1] had many complaints about [Caregiver B] and how [s/he] talked to [him/her] / treated [him/her]. [S/he] said [s/he] disrespected [him/her] verbally as well as would not get him/her a wheel chair [sic] when appropriate or help [him/her] to the bathroom. Apparently [Caregiver B] would call [Administrator A] when my [parent] asked for a wheel chair [sic] and [Administrator A] would tell [Caregiver B] (and possibly other staff) not to give [him/her] one because [s/he] was an 'independent' resident. There was an incident where [s/he] was smoking outside and called them to come help [him/her] inside to use the restroom and [Administrator A] told Them[sic] that if [s/he] got out there, [s/he] could get back in. [S/he] then soiled [himself/herself] and [Administrator A] said to let [him/her] sit in it because [s/he] thought [s/he] did it on purpose.<br><br>Another incident was specifically Monday night, August 21. [sic] My [parent] somehow made [his/her] was [sic (way)] to the kitchen without [his/her] wheel chair [sic]/oxygen and when [s/he] got there [s/he] asked for them to grab [him/her] [his/her] oxygen and wheelchair and [Caregiver B] said, 'you [sic] walked out here without it, you can walk back and get it.' This continued with my [parent] asking several more times with [Caregiver B] (and other staff watching) until [s/he] collapsed on the ground ... My [parent] also asked for help on many occasions to shower, and [Administrator A] told [his/her] staff not to help [him/her] because [s/he] was 'independent.' ...My [parent] had very old pills in [his/her] room from the time [s/he] was admitted ...After [s/he] was admitted to the hospital, the staff went through [his/her] room and 'found' those pills. They tried to say that [s/he] overdosed [himself/herself] on [his/her] old trazodone. There was a baggy in the | Y3234 | | |

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staff room with the pills that said, 'Pills that [Resident 1] took.'"

RESIDENT 2:
Resident 's date of admission was on, 07/19/2021, diagnosis unknown:

RESIDENT INTERVIEWS:
Resident 2:
On 09/14/2023, at approximately 9:40 AM, Surveyor interviewed Resident 2. Resident 2 stated, "This was a couple of months ago. [Caregiver B] was swearing at me. I got sick of it and gave it back to [him/her] ...[S/he] is loud. It's hard to take a nap because [s/he's] so loud. [S/he] called me 'Stinky pants (expletive) and Smart (expletive)'."

On 10/04/2023, at approximately 9:00 AM, Surveyor interviewed Resident 2. Resident 2 stated, " ...[Caregiver B] is very loud. It makes me nervous when [s/he's] hollering. I don't say nothing [sic] back because you can't win ...No dignity or respect ...I want to take a nap but [Caregiver B] talks to me rude [sic]. [S/he] swears at me. [S/he's] real loud at the mouth, saying, '(Expletive language).' I just be quiet. I'm sick of that crap. [S/he] says, 'Stinky pants, (expletive language),' in front of everybody. [S/he] never wants to be wrong. [S/he] thinks [s/he's] the boss. I wish [s/he] wasn't here, things would be better. [Administrator A] knows about it. The other [caregivers] knows, too."

Resident 3:
On 09/14/2023, at approximately 2:20 PM, Surveyor interviewed Resident 3. Resident 3 stated, "Saturday night, [Administrator A], [Caregiver B], and [Resident 2] came down the

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hallway. [Resident 2] grabbed [Resident 6's] chair over a little so [s/he] could go by. [Caregiver B] went off on [him/her] like [s/he] did something aggressive. [Caregiver B] called him, 'You (expletive language). Don't you dare.' [Caregiver B] was so mean that [Resident 2] went back at [her/him]. They started screaming at each other and yelling. I don't like the way [Caregiver B] talks to residents, especially [Resident 7]. [S/he] does it so much, other staff started thinking it's okay to talk to [him/her] like that. [Caregiver B] talks to [him/her] like [s/he's] dumb. [S/he's] not nice to [him/her] ...yells at [him/her] ...[s/he] says, 'Can't you see we're busy?' [S/he] makes [him/her] wait. [Resident 7] has cares, asks for things 3 to 4 times a day because [s/he] has to ask so much. It's why [s/he's] here, to get assistance. They said, 'Who cares if [s/he] wants more milk? Make [him/her] wait.' ... I told [Administrator A], [Caregiver B] needs to be calmed down [himself/herself]."

STAFF INTERVIEWS:

Caregiver F:
On 09/14/2023, at approximately 2:10 PM, Surveyor interviewed Caregiver F. Caregiver F stated, "[Caregiver B] got into it with [Resident 2]. [Caregiver B] called [Resident 2] a (expletive language) and told [him/her] [s/he] can't wait to feed [his/her] addiction. I reported this to [Administrator A]. [Caregiver Q] also told [Administrator A] that [Caregiver B] called [Resident 2] a (expletive language)."

Caregiver Q:
On 09/14/2023, at approximately 2:50 PM, Surveyor interviewed Caregiver Q. Caregiver Q stated, "[Caregiver B] screamed at [Resident 2] and made [him/her] wait. [S/he] was cursing at

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 410396 | A. BUILDING: _____ B. WING _____ | C 10/27/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GARDENVIEW INC | 1712 MIDWAY RD MENASHA, WI 54952 |

| (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 |
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[him/her], '...stinky pants ...' [Caregiver B] talks to [Resident 8] like trash, too. [Caregiver B] called [Resident 9] 'stinky pants' in the dining room, in front of other residents. I talked to [Administrator A] about [Caregiver B], but [s/he] doesn't do anything about it."

Caregiver R:
On 10/04/2023, at approximately 10:00 AM, Surveyor interviewed Caregiver R. Caregiver R stated, "... [Caregiver B] is always rushing them, telling them they can't have something when they really can."

Administrator A:
On 10/04/2023, at approximately 12:30 PM, Surveyor interviewed Administrator A. Administrator A stated, " ...[Caregiver B] has a dry sense of humor ...[S/he] jokes with [Resident 2] all the time. [S/he] tells [him/her] [s/he] can't have soda, then gives it to [him/her] ... [Caregiver B] is loud. I have spoken with [him/her] about being loud."

On 10/20/2023, at approximately 1:00 PM, Surveyor informed Administrator A, Administrator T, and Licensee U, of the findings.

Licensee U stated, "We provided what we could provide without taking away from the other residents."

Administrator A stated, "That was my biggest problem with [him/her] was that [s/he] needed so much more time than other residents."

The facility disagrees with certain facts in this citation because the facility asserts that staff who spoke with the surveyor were not always truthful in their statements or certain staff tried to

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|---|---|---|---|---|
| Y3234 | Continued From page 36<br>inappropriately influence other staff to give inaccurate information to the surveyor resulting in inaccurate facts. In addition, the facility asserts that only a portion of the police report is used as a basis for this citation and when the full police report is reviewed in conjunction with the facility's self-report and staff/resident statements, the facility believes this resident rights citation is mitigated. | Y3234 | | |