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	0010721	A. BUILDING: _____ B. WING _____	C 04/04/2024

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LIVING TREE ESTATES LLC	N1916 GREENVILLE DR GREENVILLE, WI 54942

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N 000	Initial Comments On 02/29/2024, 03/07/2024, and 04/04/2024, Surveyor conducted an on-site investigation of 1 complaint at Living Tree Estates. Additional information was gathered through 04/04/2024. The complaint was substantiated and resulted in the identification of 2 deficient practices. Two of two deficient practices were identified as repeat violations. Census: 40	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all required actions were	N 158		

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

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completed when an allegation of abuse was brought to their attention or when allegations of misconduct were documented in Resident 1's record.

On 12/24/2023, an incident of potential misconduct was documented in Resident 1's record and was not investigated as the provider did not review the notes and identify the report as potential misconduct that required investigation.

On 1/26/2024, Caregiver D reported to the provider witnessed Caregivers F, J, and Q physically restrain Resident 1 to force a shower on 01/25/2024. After learning about the allegation, the provider did not ensure all residents were immediately protected as the caregivers involved continued to work at the facility, the investigation was not immediately started, the allegations were not reported to the Department, the resident's Power of Attorney (POA) was not notified, the investigation did not include a written summary with a final conclusion, and the conclusion drawn by the provider was in direct contradiction to the evidence they were provided during their investigation. The delay in investigation process allowed for the offending caregivers to continue to work with the resident resulting in a second allegation of abuse occurring 2 days after the first.

On 01/27/2024, an allegation of misconduct was reported by Caregiver K and documented in Resident 1's record but was not identified by the provider as a separate incident of misconduct and was not investigated.

This is a repeat violation. See SOD UOIH11 (dated 07/13/2016.)

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Living Tree Estates has been licensed as a CBRF since 2005 with 47 beds that admits residents that have advanced age, physical disability, and/or irreversible dementia/Alzheimer's disease.

Findings include:

On 02/07/2024, the Department received an allegation alleging the provider did not conduct an investigation into reported abuse.

On 02/29/2024 at approximately 10:30 AM, Surveyor requested documentation for Resident 1. Surveyor reviewed Resident 1's record and noted Resident 1 was admitted to the CBRF's memory care unit on 07/12/2023 with diagnoses including: dementia with behavioral disturbance, Alzheimer's Disease, excoriation disorder, insomnia, low back pain, disorientation, and primary hyperparathyroidism. Resident 1 is listed as having an activated POA (POA R), and his/her Individual Service Plan (ISP) indicated s/he required assistance with bathing and staff to "lightly monitor" and provide "cueing to assist with ideas or needs."

Surveyor interviewed Caregiver M at 12:00 PM. Caregiver M described Resident 1 as generally pleasant and confused, and at times can be behavioral, including resisting certain cares and/or caregivers. Caregiver M stated Resident 1 is usually redirectable and when s/he refuses care, it will usually work for staff to give him/her space and then reapproach. Caregiver M stated Resident 1 requires 1 caregiver to assist with cares and can become anxious.

Surveyor interviewed HR Director B at approximately 11:45 AM. HR Director B stated s/he was aware of the allegation of abuse made

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by Caregiver D against Caregivers F, J, and Q. Regarding the process of investigating allegations, HR Director stated, "we all work together on investigations. Me (Administrator A) and (Administrative Assistant C.)" HR Director B stated s/he was unsure if an investigation had been conducted but recalled the staff involved made statements about the incident and it was noted in Resident 1's observation notes. Surveyor asked to review all records regarding the incident and steps taken by the provider.

Observation Notes
Surveyor reviewed Resident 1's observation notes and noted instances where it was documented Resident 1 was agitated or refusing cares and caregivers continued to attempt to make the resident compliant. Surveyor reviewed 3 instances of documented potential abuse:

12/24/2023, Caregiver E notes, "writer had been called into residents [sic] room by the caregiver trying to help res [sic] take a shower, staff told writer they had attempted 3 times before getting lead and resident will not take a shower. when [sic] writer had gotten [sic] into the room writer saw [sic] resident laying on [his/her] bed, [sic] writer told resident we needed to try and get into the shower [sic] when [sic] writer went to move the blankets writer noticed that the resident was completely naked, not even having socks nor [sic] underwear on. Writer [sic] told resident we would need to get some clothes on as we cannot leave [him/her] with nothing, [sic] resident had been in an aggravated state upon writer walking into the room. When [sic] writer tried to take the comfort [sic] off resident started swearing at writer, writer did get the blanket off of [his/her] and resident was still aggravated mood, [sic] writers started to get residents socks on [his/her] feet and in the

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process writer got kicked in the jaw by resident. writer [sic] managed to get both socks [sic] resident and [his/her] underwear. resident [sic] was still trying to kick staff but was not moving to get off the bed so writer grabbed the residents [sic] new pants and started to try to pull them on, [sic] writer [sic] got both legs into the pants. when [sic] writer tried to help resident with [his/her] shirt resident grabbed it from the writer's hand and threw it. writer [sic] grabbed a new shirt and went back by the bed to help resident get the top clothes on. resident [sic] did put one arm in the sleeve all the way and when writer went to reach for [his/her] other arm to guide into the sleeve [sic] resident grabbed the writers [sic] right arm and dug [his/her] fingernails into writers [sic] arm breaking the skin, [sic] resident [sic] did eventually let go of writers [sic] arm but had been digging [his/her] nails and trying to twist writers [sic] arm. once [sic] resident moved [his/her] hand writer managed to get [his/her] arm in the sleeve and as soon as [sic] resident was fully dressed writer and other caregiver left the room immediately to give residents some space/ cool down ...."

01/27/2024 Caregiver D notes, "late [sic] entry for 1/25/24 [sic] writer was working and was in [Resident 4's room] getting res.[sic] room ready for [him/her] to go to bed, when I heard res. [sic] in [Resident 1's room] yelling at staff that [s/he] was going to kill them and res. [sic] was cursing at staff. Writer went to check on res. [sic] and when writer entered the room [Caregiver Q] had res. [sic] by the neck and [Caregiver F] was restraining res. [sic] hands while [Caregiver J] was handling the water. Writer told staff to let res. [sic] go, res.[sic] looked at writer and said [sic] [sic] I didn't do nothing, they hurt me. [sic] Res. [sic] was being abused by these staff members.

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Sense [sic] when do we send 3 people to do cares on a 1 assist. This is not loving [sic] well!"

01/28/2024 Caregiver K notes, "on [sic] 1-27-24 while I worked second shift 3 caregivers went to do [Resident 1's] cares. [Resident 1] was screaming and when i [sic] was able to get [sic] [his/her] room as I [sic] couldn't leave dining/living room area isome [sic] resident [sic] were in there an [sic] I [sic] had to watch them [Resident 1] told me when I [sic] asked [him/her] if [s/he] was OK that they hurt [him/her] [sic] [s/he] [sic] was crying and asked me to get [him/her] out of here. i [sic] went over to AL side and told [Caregiver L] I [sic] felt [Resident 1] will have a heartache [sic] if the caregivers keep doing [his/her] cares as they do. [Resident 1] is a 1 assist an [sic] having 3 caregivers come at [him/her] is wrong. I BELIEVE [KITCHEN STAFF S] WAS EVEN CLOCKED OUT AT THAT TIME [sic]. [Resident 5's family] was in [his/her] room at the time an [sic] if I could hear [Resident 1] down by the kitchen they could definitely her [sic] [Resident 1.] ..." In an interview with Caregiver K on 03/07/2024 at 8:55 AM, Caregiver K identified the 3 caregivers involved as Caregivers F, J and S.

During an interview with Caregiver K on 03/14/2024 at 9:15 AM, Caregiver K stated on 01/27/2024 s/he worked and was made aware of the incident witnessed by Caregiver D that occurred on 01/25/2024. Caregiver K stated on the evening of 01/27/2024 s/he heard Resident 1 screaming and noted Caregivers F, J, and Kitchen Staff S were all in Resident 1's room. Caregiver D stated by the time s/he was able to get to Resident 1, Resident 1 was visibly upset. Caregiver K stated, "[Resident 1] was afraid. [S/he] said 'Please take me home with you; they are gonna [sic] kill me!" Caregiver K stated s/he

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found the shift lead, Caregiver L, and reported to him/her what happened. Caregiver K stated Caregiver L told Caregiver K to report it to HR Director B. Caregiver K stated s/he knew the administration (Administrator A and HR Director B) had already been made aware of the concerns from 01/25/024 and "didn't do anything about it ... no investigation was started ... they [Caregivers F, J, and Q] were still coming in for shifts." Caregiver K expressed feeling reporting was not being taken seriously and chose to write in Resident 1's observation notes so the report would be available for all caregivers and administration to see, in hopes the abuse would be addressed.

At approximately 11:00 AM, Surveyor conducted an interview with HR Director B with Administrative Assistant C present. HR Director B stated new information about each resident is passed along to the staff during a shift report and any pertinent issues or concerns are documented by the staff in the resident's observation notes. HR Director B stated it is typically Quality Control Person T who reviews caregiver documentation but that any concerns or incidents that are brought to their attention are discussed with the administrative team including lead Caregivers L and U, Administrative Assistant C, HR Director B, and Administrator A. HR Director B confirmed all of the administration team had access to the observations notes and a caregiver documenting misconduct in the resident's records constitutes the provider being made aware of the situation. After review of Resident 1's observation notes both HR Director B and Administrative Assistant C acknowledged each incident (12/24/2023 and late entry notes for 1/25/2024 and 1/27/2024) documented potential misconduct and/ or a violation of the resident's rights. HR Director B

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confirmed the documentation of the 3 incidents was available for the administrative team's review at any time and each incident should have been identified as misconduct and investigated individually. HR Director B stated the incident documented on 12/24/2024 was not investigated as the record was not reviewed and it was not identified. HR Director B stated the incident on 01/25/2024 was addressed with the witnessing caregiver (Caregiver D) and the 3 caregivers involved (Caregiver F, J and Q) but acknowledged the investigation did not start immediately after it was reported on 01/26/2024, the caregivers involved continued to work, it was not reported to the Department, all required elements of the report such as dates, times, and a conclusion were not documented, and POA F had not been contacted by the provider about the allegations of abuse. HR Director B acknowledged the incident on 01/27/2024 was not investigated as the record was not reviewed and it was not identified as a third incident. HR Director B acknowledged, had the reported caregivers been removed from resident care for the residents' immediate safety after abuse was reported to them on 01/26/2024, the caregivers would not have had the opportunity to reoffend Resident 1 on 01/27/2024.

Investigation

Surveyor note:
While providers can request complaints, allegations, and grievances be made in writing, they must accept all forms of reporting, including verbal reports. An allegation does not have to be formal or written to be reported and require an investigation.

The Wisconsin Caregiver Program Manual for

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N 158	Continued From page 8 Entities Regulated by the Division of Quality Assurance P-00038 (02/2016) (Retrival date, 05/24/2024) "Anyone who has information regarding an incident may report the incident to the entity an entity can learn of an incident from: -Verbal or written statement of a client -Verbal or written statement by someone in a position to have knowledge of the incident through --Direct or indirect observation -Discovering an incident after it occurred -Hearing about an incident from others -Observing injuries physical emotional or mental to a client -Observing misappropriation of client's property -Or otherwise becoming aware of an incident" On 02/29/2024 at approximately 2:00 PM, Surveyor interviewed Administrator A and HR Director B. Administrator A stated s/he was aware of the allegations that were reported by Caregiver D. Administrator A described an internal system for their employees when they report a "problem" with another employee. The system was referred to as "coaching" where the caregiver who has a concern "coaches" the caregiver they have a concern about by writing up the issue for review and improvement. Administrator A stated they relied upon the system to have the reporting employee determine if the issue was pertinent enough that they would take the time to write it out on the coaching form. Administrator A stated the process assisted with removing frivolous accusations between employees. After review of reporting allegations of misconduct not requiring a formal or written submission, Administrator A and HR Director B acknowledged any allegation of abuse, neglect, and/or misappropriation brought to their attention must be investigated	N 158		

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and they cannot require it to be submitted in writing to be reported. HR Director B stated s/he believed an investigation was done but did not have any associated documentation other than the caregiver's "coaching" statements. HR Director B stated there was not an outline of the investigation process including who was involved, when steps were taken, or a final summary with a resulting conclusion documented. HR Director B stated s/he was uncertain if Resident 1' POA had been notified. Administrator A and HR Director B stated they were unaware of the requirements to report the allegations to the Department.

Surveyor reviewed the coaching forms submitted as the documentation of an investigation for the incident on 01/25/2024. The form for Caregiver Q was dated 01/28/2024, Caregiver J was dated 01/292024, and Caregiver F was dated 01/30/2024. The forms revealed the witnessing Caregiver D, and 2/3 involved caregivers' (Caregivers J and Q) admission of restraining Resident 1. The third coaching form for Caregiver F's statement appears Caregiver F is referencing the incident that occurred on 01/27/2024, as it notes the involvement of Caregiver S, who was only present for the incident on 1/27/2024.

On 03/07/2024, Surveyor returned to the facility. At approximately 11:00 AM, HR Director B handed Surveyor a summary of the investigation findings. HR Director B stated s/he wrote the summary after it was brought to his/her attention through the investigation process on 02/29/2024, that the providers conclusion of their investigation findings was required. Surveyor reviewed the document:

"On January 25, 2024, Human Resources received a written complaint from [Caregiver D]

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stating that [Caregivers Q, F, and J] were physically restraining [Resident 1.] [Resident 1] was having behaviors and did not want to get in the shower. [Resident 1] kicked and bit [Caregiver F] so they did hold [his/her] hands down to protect themselves.

After interviewing [Caregiver Q, F, and J] they all stated that they would never physically restrain a resident ... they all said that they held hands down so resident could not hit them but not forcefully. [Lead Caregiver L] and [HR Director B] looked over [Resident 1's] neck, shoulders, and hands [sic] there was no sign of abuse. No bruising ..."

The summary did not match the reported action of the caregivers and concluded no abuse occurred based on no physical bruises being present. All 3 caregivers and the caregiver witness confirmed the resident was forced to take a shower, was naked, sprayed with water, and held down/ restrained. The investigation findings dismissed its own evidence that abuse occurred.

On 03/07/2024, Surveyor interviewed HR Director B with Administrative Assistant C present at approximately 12:00 PM. After a review of the code requirements, including the definitions for misconduct and abuse, and a review of the findings in the investigation summary, HR Director B acknowledged 3 people physically restraining a resident is against the resident's rights and is abuse. HR Director B stated, "Yeah they did hold [Resident 1's] hands down, yes, I see that now, they should not have done that. That is abuse."

Surveyor reviewed the timeline of the events and the date discrepancy in the provider's written conclusion. HR Director B stated s/he was

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notified by Caregiver D about the allegations of witnessing abuse the morning of 01/26/2024. HR Director B acknowledged the summary letter given to Surveyor had an incorrect date listed. The summary letter indicated s/he received the allegation report on 1/25/2024 when the incident occurred on 01/25/2024 and s/he actually received the report on 01/26/2024. HR Director B stated on 01/26/2024 s/he and Lead Caregiver L checked Resident 1 and did not see any physical signs of abuse. HR Director B stated s/he did not immediately suspend or interview the caregivers involved. Surveyor reviewed the schedule and noted Caregiver F and J returned to work on 01/26/2024 and were not interviewed. HR Director B stated s/he did not mention the incident to the caregivers until s/he interviewed them at later dates and did not offer an explanation as to why. HR Director B reviewed the dates signed by the caregivers on the coaching forms and the staffing schedule. HR Director B acknowledged after the incident on 01/25/2024, and the provider being made aware of the allegations on the morning on 01/26/2024, the residents were not immediately protected as the involved caregivers were allowed to continue to come in to work. Caregiver Q was allowed to continue to work on 01/26/2024 and 01/27/2024 and was not interviewed until 01/28/2024. Caregiver J was allowed to continue to work on 01/26/2024, 01/27/2024, 01/28/2024, and was not interviewed until 01/29/2024. Caregiver F was allowed to work on 01/26/2024, 01/27/2024, 01/28/2024, and was not interviewed until 01/30/2024. HR Director B acknowledged had the code been followed, and the caregivers involved removed from caring for the resident until the investigation was completed, Caregivers F and J would not have been present on 01/27/2024 to reoffend Resident 1, as Caregiver K documented

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N 158	Continued From page 12 occurred in Resident 1's observation notes. HR Director B stated s/he spoke with Administrator A and other staff involved in the investigation and confirmed POA R had not been contacted about the incident on 01/25/2024 or the newly identified incident on 01/27/2024. HR Director B acknowledged investigations into all 3 identified incidents were required. HR Director B acknowledged the investigation conducted for the incident on 01/25/2024 did not meet the code requirements as the investigation was delayed, the residents were not immediately protected as the caregivers were allowed to continue to work multiple shifts after the occurrence, the incident was not reported to POA F or the Department, the investigation did not contain documentation of the provider's conclusion, and the conclusion drawn was in direct conflict with the evidence that was gathered. During a subsequent interview with HR Director B and Administrator A on 04/04/2024 at 1:00 PM HR Director B stated an investigation into the incidents on 12/24/2023 and 01/27/2024 had not been conducted while Caregivers F, J, and Kitchen Staff S continued to work at the facility. Cross Reference N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment	N 158		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from	N 348		

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N 348	Continued From page 13 physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was free from abuse. On 01/25/2024 and 01/27/2024 Resident 1 refused cares and s/he was forced to shower by 3 caregivers at a time while being physically restrained. On 12/24/2023, an incident of potential abuse was documented in Resident 1's record and was not investigated. On 1/26/2024, Caregiver D reported to the provider (s/he) witnessed Caregivers F, J, and Q physically restrain Resident 1 to force a shower on 01/25/2024. The provider allowed the caregivers to continue to work with the resident resulting in a second allegation of abuse occurring 2 days after the first. On 01/27/2024, an allegation of abuse was reported by Caregiver K and documented in Resident 1's record but was not identified by the provider as a separate incident of abuse and was not investigated. This is a repeat violation. See SOD UOIH11 (dated 07/13/2016.) Living Tree Estates has been licensed as a CBRF since 2005 with 47 beds that admits residents that have advanced age, physical disability,	N 348		

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N 348	Continued From page 14 and/or irreversible dementia/Alzheimer's disease. Findings include: On 02/07/2024, the Department received an allegation alleging resident abuse. Misconduct Definitions https://www.dhs.wisconsin.gov/publications/p00976.pdf (Retrieval date, 05/24/2024) " "Abuse" is defined as: 1. An act or repeated acts by a caregiver or non-client resident, including but not limited to restraint, isolation, or confinement that, when contrary to the entities policy and procedures, not part of the to clients treatment plan and done intentionally to cause harm, does any of the following: a. Causes or could it be reasonably expected to cause pain or injury to a client or the death of a client and the act does not constitute self-defense as defined in Wis. Stat. 9 39.48. b. Substantially disregards a client's rights under Wis. Stat chs. 50 or 51, or caregiver's duties and obligations to a client. c. Causes or could reasonably be expected to cause mental or emotional damage to a client, including harm to the client's psychological or intellectual functioning that exhibited by anxiety, depression, withdrawal, regression, outward aggressive behavior, agitation, or a fear of harm or death, or a combination of these behaviors. This subdivision does not apply to a permissible restraint isolation or confinement implemented by order of a court or as permitted by statue ... 4. A course of conduct or repeated acts by a caregiver which serve no legitimate purpose and which, when done with intent to harass,	N 348		

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intimidate, humiliate, threaten, or frighten a client, causes or could be reasonably expected to cause the client to be harassed, intimidated, humiliated, threatened, or frightened."

On 02/29/2024 at approximately 10:30 AM, Surveyor requested documentation for Resident 1. Surveyor reviewed Resident 1's record and noted Resident 1 was admitted to the CBRF's memory care unit on 07/12/2023 with diagnoses including: dementia with behavioral disturbance, Alzheimer's Disease, excoriation disorder, insomnia, low back pain, disorientation, and primary hyperparathyroidism. Resident 1 is listed as having an activated POA (POA R), and his/her Individual Service Plan (ISP) indicated s/he required assistance with bathing and staff to "lightly monitor" and provide "cueing to assist with ideas or needs."

Surveyor interviewed Caregiver M at 12:00 PM. Caregiver M described Resident 1 as generally pleasant and confused, and at times can be behavioral, including resisting certain cares and/or caregivers. Caregiver M stated Resident 1 is usually redirectable and when s/he refuses care, it will usually work for staff to give him/her space and then reapproach. Caregiver M stated Resident 1 requires 1 caregiver to assist with cares and can become anxious.

On 3/14/2024 at 12:45 PM, Surveyor interviewed Caregiver D who was a witness and reporter of the abuse that occurred on 01/25/2024. Caregiver D stated, "I was working on PM shift, and it was on the 25th ... I was in one of the other resident's rooms ... and I heard 'I'm gonna {sic} kill you! Get the {explicative} out!' ... When I went next door into [Resident 1's] room I seen [sic] [Caregiver Q] with [his/her] hands around [Resident 1's] neck

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and I seen [sic] there are 3 [caregivers] ... [Caregiver F] was restraining [Resident 1's] arms ... and [Caregiver J] ... had to shut the shower handle because they were trying to get [him/her] into a shower. I said to let [him/her] go. [Resident 1] was naked ... they let [him/her] go and [Resident 1] looked straight at me and said 'I didn't do nothing wrong. They're hurting me.' They continued to do the shower. [Caregiver Q] left the room, the one that was restraining [Resident 1] by [his/her] neck, and [Caregiver J] just started spraying [Resident 1] in the face with the water ... [Caregiver F] again grabbed [his/her] hands to restrain [him/her.] At this point now [Resident 1's] fighting back ... so they put [him/her] in the shower, got [him/her] dressed and put [him/her] in bed. When I walked out, I said, 'Is this what you guys do all the time?' They said 'yeah.' ... I want good caregivers not what I seen [sic] because it made me sick to my stomach ... that's not how you take care of resident ...I called [HR Director B] I left a message. [S/he] didn't get back to me of course it's nighttime ... so first thing in the morning I called [HR Director] and I told [him/he] what I witnessed, and I did the coaching slips. I put my observation in and nothing. I didn't hear anything ... So, Friday I'm still sick to my stomach that this happened, so I called that night ... I just ... I wanna [sic] cry right now because it's stuck in my gut."

On 02/29/2024 at approximately 11:45 AM, Surveyor interviewed HR Director B. HR Director B stated s/he was aware of the allegation of abuse made by Caregiver D against Caregivers F, J, and Q. Surveyor asked to review all records regarding the incident and steps taken by the provider.

Observation Notes

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N 348	Continued From page 17 On 02/29/2024, Surveyor reviewed Resident 1's observation notes and noted instances where it was documented Resident 1 was agitated or refusing cares and caregivers continued to attempt to make the resident compliant. Surveyor reviewed 3 instances of documented potential abuse: 12/24/2023, Caregiver E notes, "writer had been called into residents [sic] room by the caregiver trying to help res [sic] take a shower, staff told writer they had attempted 3 times before getting lead and resident will not take a shower. when [sic] writer had gotten [sic] into the room writer saw [sic] resident laying on [his/her] bed, [sic] writer told resident we needed to try and get into the shower [sic] when [sic] writer went to move the blankets writer noticed that the resident was completely naked, not even having socks nor [sic] underwear on. Writer [sic] told resident we would need to get some clothes on as we cannot leave [him/her] with nothing, [sic] resident had been in an aggravated state upon writer walking into the room. When [sic] writer tried to take the comfort [sic] off resident started swearing at writer, writer did get the blanket off of [his/her] and resident was still aggravated mood, [sic] writers started to get residents socks on [his/her] feet and in the process writer got kicked in the jaw by resident. writer [sic] managed to get both socks [sic] resident and [his/her] underwear. resident [sic] was still trying to kick staff but was not moving to get off the bed so writer grabbed the residents [sic] new pants and started to try to pull them on, [sic] writer [sic] got both legs into the pants. when [sic] writer tried to help resident with [his/her] shirt resident grabbed it from the writer's hand and threw it. writer [sic] grabbed a new shirt and went back by the bed to help resident get the top clothes on. resident [sic] did put one arm in the	N 348		

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sleeve all the way and when writer went to reach for [his/her] other arm to guide into the sleeve [sic] resident grabbed the writers [sic] right arm and dug [his/her] fingernails into writers [sic] arm breaking the skin, [sic] resident [sic] did eventually let go of writers [sic] arm but had been digging [his/her] nails and trying to twist writers [sic] arm. once [sic] resident moved [his/her] hand writer managed to get [his/her] arm in the sleeve and as soon as [sic] resident was fully dressed writer and other caregiver left the room immediately to give residents some space/ cool down ...."

01/27/2024 Caregiver D notes, "late [sic] entry for 1/25/24 [sic] writer was working and was in [Resident 4's room] getting res.[sic] room ready for [him/her] to go to bed, when I heard res. [sic] in [Resident 1's room] yelling at staff that [s/he] was going to kill them and res. [sic] was cursing at staff. Writer went to check on res. [sic] and when writer entered the room [Caregiver Q] had res. [sic] by the neck and [Caregiver F] was restraining res. [sic] hands while [Caregiver J] was handling the water. Writer told staff to let res. [sic] go, res.[sic] looked at writer and said [sic] [sic] I didn't do nothing, they hurt me. [sic] Res. [sic] was being abused by these staff members. Sense [sic] when do we send 3 people to do cares on a 1 assist. This is not loving [sic] well!"

01/28/2024 Caregiver K notes, "on [sic] 1-27-24 while I worked second shift 3 caregivers went to do [Resident 1's] cares. [Resident 1] was screaming and when i [sic] was able to get [sic] [his/her] room as I [sic] couldn't leave dining/living room area isome [sic] resident [sic] were in there an [sic] I [sic] had to watch them [Resident 1] told me when I [sic] asked [him/her] if [s/he] was OK that they hurt [him/her] [sic] [s/he] [sic] was crying

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and asked me to get [him/her] out of here. i [sic] went over to AL side and told [Caregiver L] I [sic] felt [Resident 1] will have a heartache [sic] if the caregivers keep doing [his/her] cares as they do. [Resident 1] is a 1 assist an [sic] having 3 caregivers come at [him/her] is wrong. I BELIEVE [KITCHEN STAFF S] WAS EVEN CLOCKED OUT AT THAT TIME [sic]. [Resident 5's family] was in [his/her] room at the time an [sic] if I could hear [Resident 1] down by the kitchen they could definitely her [sic] [Resident 1.] ..." In an interview with Caregiver K on 03/07/2024 at 8:55 AM, Caregiver K identified the 3 caregivers involved as Caregivers F, J and S.

During an interview with Caregiver K on 03/14/2024 at 9:15 AM, Caregiver K stated on 01/27/2024 s/he worked and was made aware of the incident witnessed by Caregiver D that occurred on 01/25/2024. Caregiver K stated on the evening of 01/27/2024 s/he heard Resident 1 screaming and noted Caregivers F, J, and Kitchen Staff S were all in Resident 1's room. Caregiver D stated by the time s/he was able to get to Resident 1, Resident 1 was visibly upset. Caregiver K stated, "[Resident 1] was afraid. [S/he] said 'Please take me home with you; they are gonna [sic] kill me!" Caregiver K stated s/he found the shift lead, Caregiver L, and reported to him/her what happened. Caregiver K stated Caregiver L told Caregiver K to report it to HR Director B. Caregiver K stated s/he knew the administration (Administrator A and HR Director B) had already been made aware of the concerns from 01/25/024 and "didn't do anything about it ... no investigation was started ... they [Caregivers F, J, and Q] were still coming in for shifts." Caregiver K expressed feeling reporting was not being taken seriously and chose to write in Resident 1's observation notes so the report

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would be available for all caregivers and administration to see, in hopes the abuse would be addressed.

On 02/29/2024 at approximately 11:00 AM, Surveyor conducted an interview with HR Director B with Administrative Assistant C present. HR Director B confirmed all of the administration team (Lead Caregivers L and U, Administrative Assistant C, HR Director B, and Administrator A) had access to the observations notes and a caregiver documenting misconduct in the resident's records constitutes the provider being made aware of the situation. After review of Resident 1's observation notes both HR Director B and Administrative Assistant C acknowledged each incident (12/24/2023 and late entry notes for 1/25/2024 and 1/27/2024) documented abuse and/ or a violation of the resident's rights. HR Director B confirmed the documentation of the 3 incidents was available for the administrative team's review at any time and each incident should have been identified as misconduct and investigated individually. HR Director B stated the incident documented on 12/24/2024 was not investigated as the record was not reviewed and it was not identified. HR Director B stated the incident on 01/25/2024 was addressed with the witnessing caregiver (Caregiver D) and the 3 caregivers involved (Caregiver F, J and Q) but acknowledged the investigation did not start immediately after it was reported on 01/26/2024, the caregivers involved continued to work, it was not reported to the Department, all required elements of the report such as dates, times, and a conclusion were not documented, and POA F had not been contacted by the provider about the allegations of abuse. HR Director B acknowledged the incident on 01/27/2024 was not investigated as the record was not reviewed

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and it was not identified as a third incident. HR Director B acknowledged, had the reported caregivers been removed from resident care for the residents' immediate safety after abuse was reported to them on 01/26/2024, the caregivers would not have had the opportunity to reoffend Resident 1 on 01/27/2024.

Surveyor reviewed the coaching forms submitted as the documentation of an investigation for the incident on 01/25/2024. The forms revealed the witnessing Caregiver D, and Caregivers J and Q's admission of restraining Resident 1. The third coaching form for Caregiver F's statement appears Caregiver F is referencing an incident on 01/27/2024, as it notes the involvement of Caregiver S, who was only present for the incident on 1/27/2024.

Dated 1/30/2024, Caregiver D to Caregiver F: Coaching form that notes the persons involved in the incident on 01/27/2024 but was submitted as documentation for the incident on 01/25/2024:

"Identified behavior and risk to residents or employees:

(Caregiver D writes) During cares writer [Caregiver D] witness [sic] care staff physically restraining res. [sic] hands while trying to get res. [sic] in the shower. I told them to let go and [sic] continued to restrain res. [sic] while putting in shower (res. [sic] stated 'I didn't do nothing [sic] they hurt me.'

Employee's perception/ response:
(HR Director B writes Caregiver F's response) [Resident 1] bit [Caregiver F] in [sic] the cheek three times. [S/he] was sitting on the toilet at that time [Caregiver F] was trying to take shoes off

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[Caregiver J] left when [Caregiver D] came in. [Kitchen Staff S] and [Caregiver F] finished shower. [Caregiver D] [sic] congratulations because you did a good job [sic] [Caregiver D] just walked in and said nothing. [Caregiver J] left scared ..."

Dated 1/29/2024, Caregiver D to Caregiver J:

"Identified behavior and risk to residents or employees:

(Caregiver D writes) "writer [sic] didn't notice staff [Caregiver J] being involved in any physical abuse but was involved in mental [sic] emotional abuse by not stopping the other caregivers. [sic] for the way [Caregiver J] turned water on started to just spray res. [sic] again res. [sic] stated 'I didn't do nothing wrong they hurt me.'

Employee's perception/ response:
(HR Director B writes Caregiver J's response)
[Caregiver J] said they were trying to get [him/her] in [sic] shower [sic] never held [sic] neck [sic] just hands down because [sic] aggressive ..."

Dated 01/28/2024, Caregiver D to Caregiver Q:

"Identified behavior and risk to residents or employees:

(Caregiver D writes) "During cares on [resident 1] I [sic] [Caregiver D] witnessed [Caregiver Q] physically restraining res. [sic] by the neck. writer [sic] told staff to let go and staff didn't listen [sic] continued shoving shower chair in [sic] shower. res. [sic] stated [sic] 'I didn't do nothing they hurt me.'

Employee's perception/ response:

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(HR Director B writes Caregiver Q's response) '[sic] said [sic] this was not true' said '[s/he] would never grab a resident or restrain' [sic] said [sic] resident kicked and bit [Caregiver F.] They did hold hand down so [s/he] would not hit them ..."

On 03/07/2024 Surveyor returned to the facility. At approximately 11:00 AM, HR Director B handed Surveyor a summary of the investigation findings. HR Director B stated s/he wrote the summary after it was brought to his/her attention through the investigation process on 02/29/2024 that a summary of the investigation findings was required. Surveyor reviewed the document:

"On January 25, 2024, Human Resources received a written complaint from [Caregiver D] stating that [Caregivers Q, F, and J] were physically restraining [Resident 1.] [Resident 1] was having behaviors and did not want to get in the shower. [Resident 1] kicked and bit [Caregiver F] so they did hold [his/her] hands down to protect themselves.

After interviewing [Caregiver Q, F, and J] they all stated that they would never physically restrain a resident ... they all said that they held hands down so resident could not hit them but not forcefully. [Lead Caregiver L] and [HR Director B] looked over [Resident 1's] neck, shoulders, and hands [sic] there was no sign of abuse. No bruising ..."

The summary did not match the reported action of the caregivers and concluded no abuse occurred based on no physical bruises being present. All 3 caregivers and the caregiver witness confirmed the resident was forced to take a shower, was naked, sprayed with water, and held down/ restrained. The investigation findings dismissed its own evidence that abuse occurred.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING TREE ESTATES LLC	N1916 GREENVILLE DR GREENVILLE, WI 54942

(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 348	Continued From page 24 On 03/07/2024, Surveyor interviewed HR Director B with Administrative Assistant C present at approximately 12:00 PM. After a review of the code requirements, including the definitions for misconduct and abuse, and a review of the findings in the investigation summary, HR Director B acknowledged physically restraining a resident is against the resident's rights and is abuse. HR Director B stated, "Yeah, they did hold [Resident 1's] hands down, yes, I see that now, they should not have done that. That is abuse." HR Director B acknowledged abuse is not limited to physical bruising being present. HR Director B acknowledged the mental and/ or emotional abuse that is caused when caregivers, who are supposed to be trusted with private care, do not respect the privacy of only wanting 1 caregiver to assist and have 3 caregivers forcibly undress the resident, hold him/her down and spray him/her with water. HR Director B stated all of the caregivers involved had been trained on resident rights, including abuse, and were aware restraining a resident was abuse. HR Director B acknowledged the pattern of treatment including the documented incident on 12/24/2023 and acknowledged incidents that occurred on 01/25/2024 and 01/27/2024 constituted abuse of Resident 1 occurred. Cross Reference N0158 DHS 83.12.(2)(a) Caregiver: Investigating Abuse & Neglect	N 348		