STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014577	A. BUILDING: _____ B. WING _____	C 08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE HALLIE MEMORY CARE	**4407 124TH STREET CHIPPEWA FALLS, WI 54729**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 08/13/2024, Surveyor conducted a standard licensure survey, 5 complaints, and a self-report survey at Lake Hallie Memory Care. Data was collected through 08/21/2024. Four of the 5 complaints were substantiated. Six deficiencies were identified. Two of the 6 deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) 728P13, dated 12/08/2022, and SOD 728P12, dated 08/17/2022. Census: 54	N 000		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct and document caregiver	N 219		

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

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N 219	Continued From page 1 background checks, following the procedures in s.50.065, Stats., for 1 of 5 caregivers reviewed. The provider did not obtain a copy of Caregiver E's criminal complaint and judgment of conviction related to Caregiver E's conviction of a violation of s. 947.01 (disorderly conduct), dated 12/27/2023. Findings include: On 08/14/2024, Surveyor reviewed 5 employee's caregiver background checks (CBC). Caregiver E's date of hire was 11/08/2023. Caregiver E's Department of Justice (DOJ) report, dated 11/09/2023, indicated Caregiver E was charged with disorderly conduct and battery on 05/26/2023. An additional DOJ report in Caregiver E's file indicated Caregiver E was convicted of disorderly conduct on 12/27/2023. The battery charges were dismissed. Caregiver E's file did not contain the criminal complaint and judgement of conviction related to his/her disorderly conduct conviction. On 08/14/2024 at 12:35 p.m., Surveyor interviewed Administrator A. Administrator A told Surveyor they did not have the criminal complaint and judgment of conviction related to Caregiver E's disorderly conduct conviction.	N 219		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from	N 358		

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N 358	Continued From page 2	N 358		

environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities.

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the provider did not provide a safe environment for Resident 4 to eat, which placed him/her at risk for choking and aspiration.

Findings include:

On 06/26/2024, the Department received a complaint with multiple allegations, including an allegation staff did not position a resident who ate in his/her room, in an upright position.

On 08/13/2024 at 7:45 a.m., Surveyor interviewed Caregiver F. Caregiver F told Surveyor Resident 4 did not want to get up and requested his/her breakfast in his/her room.

At approximately 8:10 a.m., Surveyor observed dietary staff bring a tray into Resident 4's room.

At 8:23 a.m., Surveyor observed Environment Services (ES) G approach Caregiver F and ask Caregiver F to assist Resident 4 in sitting up in his/her bed. ES G told Caregiver F, "[S/he] can't eat right the way [s/he] is." Caregiver F was assisting Resident 2 and Resident 3 with eating their breakfast.

At 8:30 a.m., Surveyor observed Resident 4. S/he was eating breakfast in his/her bed. The bed was less than 45 degrees and Resident 4 was scooted down in the bed. Resident 4 was drinking

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N 358	Continued From page 3 out of a straw and s/he finished his/her cereal. At 8:43 a.m., Surveyor observed Caregiver H in the dining room. Caregiver F asked Caregiver H if s/he would assist in siting Resident 4 upright in bed. Caregiver H called on his/her radio for another staff to come to the dining room. At 8:51 a.m., Surveyor observed Caregiver H and Caregiver F in Resident 4's room. Caregiver F told Resident 4, "Oh, you were able to finish your breakfast." Surveyor asked Caregiver H, who was responsible for ensuring Resident 4 was upright in bed for meals. Caregiver H said whoever was working that quad was responsible. S/he said Resident 4 was scooted down in bed, and Caregiver F needed help to boost him/her up. On 08/14/2024, Surveyor reviewed Resident 4's record. Resident 4 had multiple diagnoses, including a cerebrovascular accident (stroke). S/he had an activated health care power of attorney and was on hospice. Resident 4's individual service plan (ISP), with a print date of 08/13/2024, indicated Resident 4 had a mechanical soft diet due to chewing/swallowing difficulties. The ISP indicated Resident 4 did not have teeth. Resident 4 was at risk for aspiration and choking based on his/her diagnosis of a stroke and not having any teeth. Staff did not position Resident 4 upright in bed to ensure a safe eating environment.	N 358		

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N 388	Continued From page 4	N 388		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure each resident's individual service plan (ISP) was implemented as written, for 3 of 6 residents reviewed. Staff did not implement Resident 2's toileting schedule. Staff did not implement Resident 3's alarm, toileting schedule, or assistance 3 to bed after breakfast. Staff did not implement Resident 6's alarm. Findings include: From 06/03/2024 - 07/12/2024, the Department received 4 complaints alleging residents' toileting schedules were not being followed, and there were multiple falls. RESIDENT 2 On 08/13/2024 at 5:30 a.m., Surveyor observed Resident 2 was awake and sitting in his/her Broda chair in his/her room in front of the TV. Surveyor continued to make observations throughout the morning. Resident 2 remained in his/her Broda chair in his/her room until 7:37 a.m. At 7:37 a.m., Caregiver F pushed Resident 2 out to the dining room for breakfast.	N 388		

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N 388	Continued From page 5 At 7:45 a.m., Surveyor interviewed Caregiver F. Caregiver F told Surveyor the night shift got Resident 2 up for the day. At 9:26 a.m., Surveyor observed Caregiver F push Resident 2 from the dining room to the bistro for activities. Resident 2 remained in the bistro until 10:25 a.m. At 10:25 a.m., Caregiver H came and pushed Resident 2 back to his/her room. Surveyor asked if Caregiver H did any cares that morning for Resident 2. Caregiver H said, "No." S/he said Resident 2 was up this morning when they arrived. At 10:30 a.m., Surveyor observed Caregiver F and Caregiver I transfer Resident 2 from his/her chair to the bed and change his/her incontinent pad. Surveyor asked if that was the first time cares were provided. Caregiver F confirmed it was the first time cares were provided for Resident 2 since night shift got Resident 2 up. Resident 2 remained seated in his/her Broda chair from 5:30 a.m. - 10:30 a.m. On 08/14/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 03/28/2023 and had multiple diagnoses including Alzheimer's dementia, depression/anxiety, encephalopathy (disorder of the brain), and weakness. Resident 2's ISP, with a print date of 08/13/2024, indicated Resident 2 was dependent on staff for activities of daily living (ADLs) and mobility. Resident 2 was incontinent of bladder and bowel. S/he was on a 2-hour toileting schedule. The ISP read, in part: "Resident is on a 2-hour toileting	N 388		

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N 388	Continued From page 6	N 388		

program due to frequent incontinence... Resident is at risk for skin breakdown due to incontinence and inability to reposition self/bony prominences."

Staff did not change or reposition Resident 2 for 5 hours.

RESIDENT 3

On 08/13/2024 at approximately 7:00 a.m., Surveyor observed Caregiver F and Caregiver H assist Resident 3 with morning cares, including incontinence cares, and getting dressed and into his/her wheelchair. Surveyor observed an alarm on Resident 3's TV stand. The alarm did not sound. Surveyor picked it up and asked the caregivers if Resident 3 required the alarm. Caregiver H told Surveyor s/he was unsure if the alarm was part of Resident 3's care plan. Caregiver F told Surveyor s/he was new and only assisted Resident 3 once before. Caregiver F pushed Resident 3 out to the dining room when his/her cares were completed.

At 9:26 a.m., Surveyor observed Caregiver J push Resident 3 from the dining room to the bistro for activities.

At 11:04 a.m., Surveyor observed Caregiver F and Caregiver I assist Resident 3 back to his/her room to be changed.

Surveyor kept Resident 3 in line of sight. Resident 3 remained seated in his/her wheelchair from 7:00 a.m. until 11:04 a.m.

On 08/14/2024, Surveyor reviewed Resident 3's record.

Resident 3 was admitted on 08/26/2021. S/he

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had multiple diagnoses including: Alzheimer's disease, history of recurrent urinary tract infections, and arthritis.

Resident 3's ISP, with a print date of 08/13/2024, indicated Resident 3 required total assistance for self-care and was not able to make his/her needs known. His/her ISP read, in part: "Resident is on a 2-hour toileting program due to bowel and bladder incontinence... Resident utilizes a motion alarm at all times. Alarm is to be placed by resident on the floor. Resident needs this to alert staff when resident is attempting to transfer without assistance and to minimize the risk of serious injuries related to falls... Per hospice, ensure resident is laid down in bed and that [his/her] feet are elevated after each meal."

Resident 3's motion alarm was not in use. Staff did not assist Resident 3 with toileting every 2 hours. Resident 3 did not get changed from 7:00 a.m. - 11:00 a.m. Staff did not assist Resident 3 to bed and elevate his/her legs after breakfast.

RESIDENT 6

On 08/14/2024, Surveyor reviewed Resident 6's record.

Resident 6 was admitted to the facility on 02/15/2023. S/he had multiple diagnoses, including vascular dementia with agitation, depression, encephalopathy, muscle weakness, and hallucinations.

Resident 6's ISP, with a print date of 08/13/2024, read, in part: "Resident utilizes a tab alarm at all times. Resident needs this to alert staff when resident is attempting to transfer without assistance/to minimize the risk of serious injuries

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N 388	Continued From page 8 related to falls." From 03/25/2024 - 08/13/2024, Resident 6 had 20 falls. On 04/27/2024, Resident 6 fell and fractured his/her femur. A fall investigation, dated 05/08/2024, included the following interventions to prevent future incidents: "Based on investigation, it appears as if resident was attempting to self-transfer out of bed leading to [his/her] fall. Due to this fall, resident was given a tab alarm until [his/her] ordered pressure alarm is delivered..." A fall investigation, dated 05/11/2024, indicated Resident 6 fell when attempting to transfer him/herself from the wheelchair. The alarm was marked as "N/A" (non-applicable). A fall investigation, dated 06/04/2024, read, in part: "Based on investigation, it appears as if resident attempted to self-transfer/self-ambulate without [his/her] tab alarm on. Due to this fall, re-education will be provided to staff about ensuring a resident's tab alarm is on at all times." A fall investigation, dated 06/08/2024, read, in part: "Based on this investigation, resident was trying to get up and walk but due to alarm not being utilized properly, resident fell. Due to this, staff were educated on the importance of alarms and alarm checks." Staff did not always utilize an alarm according to Resident 6's ISP.	N 388		

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N 397	Continued From page 9	N 397		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure there was a qualified resident care staff present in the facility at all times to administer medications. Findings include: On 07/08/2024, the Department received a complaint related to staffing concerns and not always having a staff member on duty that was qualified to administer medications.	N 397		

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N 397	Continued From page 10 This facility is licensed to care for up to 64 residents in the client group irreversible dementia/Alzheimer's disease. Wis. Admin. Code § DHS 83.02(42) defines a qualified resident care staff as: "an employee who has successfully completed all of the applicable training and orientation under subch. IV." On 08/14/2024, Surveyor reviewed the employee schedule from June 2024 - August 13, 2024. The schedule did not identify who the qualified staff person to administer medications was on the following dates and times: On 06/10/2024, there was no medication passer assigned on the schedule from 8:00 p.m. - 9:00 p.m. On 06/14/2024, there was no medication passer assigned from 8:00 p.m. - 10:30 p.m. On 07/07/2024, there was no medication passer assigned to the overnight shift from 10:30 p.m. - 6:30 a.m. On 07/11/2024, there was no medication passer assigned on the overnight shift from 2:00 a.m. - 6:00 a.m. A note on the schedule read, "From 2 - 6 AM call [Resident Health Coordinator (RHC) K] or [Caregiver L] if PRN (as needed) medication is needed. Anything else call [RHC M]." On 07/29/2024, there was no medication passer assigned on the overnight shift from 10:30 p.m. - 6:30 a.m. On 08/14/2024 at approximately 3:30 p.m., Surveyor interviewed Administrator A, Director of Nursing B, and Assistant Administrator C.	N 397		

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N 397	Continued From page 11 Surveyor requested documentation clarifying who the qualified medication passer was on the above dates and times. On 08/15/2024, Administrator A emailed Surveyor copies of the schedule for the dates above. These schedules did not match the original schedules Surveyor reviewed on 08/14/2024. On 08/20/2024, Surveyor emailed Administrator A and requested the time sheets for a sample of employees on the schedules that did not match. On 08/21/2024 at 11:04 a.m., Surveyor spoke to Administrator A on the phone. Administrator A told Surveyor there were discrepancies with the schedules that were provided and the time sheets. S/he said the scheduler was placed on suspension pending an investigation. Surveyor asked if there were dates and times there was not an assigned mediation passer in the building. Administrator A said, "It's looking like that right now." S/he added they will need to do an investigation as some staff do not always clock in correctly. Cross Reference N0397 DHS 83.36(2) Maintain Current Written Staffing Schedule	N 397		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by:	N 399		

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Based on record review and interview, the provider did not maintain a current written staff schedule to accurately reflect the time worked by employees.

This is a repeat deficiency. See Statement of Deficiency (SOD) 728P13, dated 12/08/2022.

Findings include:

Between 06/03/2024 - 07/12/2024, the Department received 4 complaints alleging the facility did not have adequate staffing.

This facility is licensed to care for up to 64 residents in the client group irreversible dementia/Alzheimer's disease.

On 08/14/2024, Surveyor reviewed the employee schedule from June 2024 - August 13, 2024. The schedule did not identify a qualified staff person to administer medications for the entire shift on the following dates: 06/10/2024 p.m. shift, 06/14/2024 p.m. shift, 07/07/2024 overnight shift, 07/11/2024 overnight shift, and 07/29/2024 overnight shift.

On 08/14/2024 at approximately 3:30 p.m., Surveyor interviewed Administrator A, Director of Nursing B, and Assistant Administrator C. Surveyor requested documentation clarifying who the qualified medication passer was on the above dates and shifts.

On 08/15/2024, Administrator A emailed Surveyor copies of the schedule for the dates above. These schedules did not match the original schedules Surveyor reviewed on 08/14/2024.

On 08/20/2024, Surveyor emailed Administrator A

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and requested the time sheets for Resident Health Coordinator (RHC) K, Caregiver L, Caregiver N, Caregiver O, and Caregiver P.

On 08/21/2024, Surveyor reviewed the time sheets and schedules. Surveyor identified the following discrepancies between the schedule and the time sheets:

On 06/10/2024, the first schedule identified Caregiver N worked from 2:15 p.m. - 8:00 p.m. The second schedule indicated Caregiver N worked from 2:15 p.m. - 10:45 p.m. Caregiver N's time sheet indicated s/he worked from 2:38 p.m. - 9:17 p.m.

On 06/14/2024, the first schedule indicated RHC K worked from 2:15 p.m. - 8:00 p.m. The second schedule indicated RHC K worked from 2:15 p.m. - 10:45 p.m. RHC K's time sheet indicated s/he worked from 12:45 p.m. - 9:47 p.m.

On 07/07/2024, the first schedule indicated Caregiver L worked from 2:15 p.m. - 10:45 p.m. The second schedule indicated Caregiver L worked from 10:30 p.m. - 2:00 a.m. Caregiver L's time sheet indicated s/he worked 2:00 a.m. - 6:20 a.m. and then returned to work 6:26 p.m. - 11:02 p.m.

On 07/11/2024, the first schedule did not include a medication passer from 2:00 a.m. - 6:30 a.m. The second schedule indicated Caregiver O worked from 2:00 a.m.- 6:30 a.m. Caregiver O's time sheet indicated s/he did not work on 07/11/2024 and s/he started work at 6:18 a.m. on 07/12/2024.

On 07/29/2024, the first schedule indicated Caregiver P called in and did not work. The

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N 399	Continued From page 14 second schedule indicated Caregiver P worked from 10:30 p.m. - 6:30 a.m. Caregiver P's time sheet indicated s/he did not work 07/29/2024 or 07/30/2024. On 08/21/2024 at 11:04 a.m., Surveyor spoke to Administrator A on the phone. Administrator A told Surveyor there were discrepancies with the schedules that were provided and the time sheets. S/he said the scheduler was placed on suspension pending an investigation.	N 399		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide adequate supervision to keep Resident 1 from entering other residents' rooms and to prevent resident to resident altercations. This requirement is being cited for the third time. See Statement of Deficiency (SOD) 728P12, dated 08/17/2022 and SOD 728P13, dated 12/08/2022.	N 426		

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N 426	Continued From page 15 Findings include: On 08/05/2024, the Department received a self-report related to a fall that resulted in death. The report read, in part, "In the early morning hours of 08/05/2024 (Note: Review of Resident 5's record and interviews with Caregiver D and Caregiver Q reveal the date of the incident was 07/31/2024), around 1:30 am, staff [Caregiver D] reports [s/he] heard loud screaming coming from [Resident 5]'s room ... Upon entry staff notes that [Resident 5] was on the floor next to [his/her] bed and recliner, with another Resident [sic] standing over [him/her]. It is unknown whether the other Resident [sic] entered the room prior to or subsequent to the fall. Staff removed the other Resident [sic] and redirected [him/her] back to [his/her] room. [Resident 5] was bleeding from [his/her] head and nose ... EMS (emergency medical services) summoned to transport to ED (emergency department) ... Upon assessment at ED, it was determined [Resident 5] had sustained a pelvic fracture as well as a small acute frontal parafalcine hematoma (blood trapped between the inner layers of the brain and the outer covering of the brain) ... Upon review of the CT (computed tomography) was discovered [s/he] had a focal intraparenchymal hemorrhage (bleeding in the brain) in the left frontal tissue as well as large amount of intraparenchymal hemorrhage as well as scattered subarachnoid hemorrhage. [Resident 5]'s family including POA (power of attorney) was consulted and elected on full comfort cares. [Resident 5] passed away later the same day with the suspected cause of death to be due to [his/her] intracranial hemorrhages." On 08/13/2024, Surveyor reviewed the discharged residents. Resident 5 was discharged	N 426		

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N 426	Continued From page 16 on 07/31/2024 due to death. On 08/14/2024 at approximately 9:45 a.m., Surveyor interviewed Caregiver Q. Caregiver Q told Surveyor s/he was working the night Resident 5 had an accident. Surveyor asked who was working that night. S/he said s/he was training Caregiver R that night, Caregiver D was working the Delta quad where Resident 5 resided, and Caregiver S was the medication passer. Caregiver Q told Surveyor Caregiver S was sleeping on duty that night. S/he said Resident 5 did not get up at night unless s/he was incontinent. Caregiver Q told Surveyor Resident 1 did wander at night and did have a history of being aggressive with other residents and staff. S/he said it took time for Caregiver S to answer his/her walkie when Caregiver D called for help. Caregiver Q told Surveyor his/her trainee, Caregiver R, took a picture of Caregiver S sleeping and sent it to management. S/he said Caregiver R no longer worked at this facility. On 08/14/2024 from 1:49 p.m. - 2:15 p.m., Surveyor interviewed Caregiver D on the phone. Caregiver D told Surveyor s/he was the one to find Resident 5 after his/her incident. Caregiver D said Resident 7 was wandering around the facility that night. Caregiver D said s/he was walking Resident 7 back to his/her room, which was on a different quad when s/he heard screaming. Caregiver D said s/he paused and thought maybe it was the TV, and then s/he said s/he ran back to Delta quad and found Resident 5 lying face down on his/her floor with Resident 1 standing over the top of Resident 5. S/he said Resident 1 had one leg on one side of Resident 5 and his/her other leg on the other side of Resident 5. S/he said Resident 1 was naked and holding a soaker pad. Caregiver D said s/he guided Resident 1 away	N 426		

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from Resident 5 and directed him/her to go back to his/her own room, which was across the hall. Caregiver D said Resident 5 told him/her: "That [lady/man] told me to get up and walk." Caregiver D said s/he asked Resident 5 if s/he was talking about Resident 1. Caregiver D said Resident 5 told him/her, "yes, yes, yes." Caregiver D said Resident 5 was screaming in pain. S/he said s/he tried to assist but there was blood coming from his/her head and nose. Caregiver D said s/he radioed 3 times before the medication passer, Caregiver S, responded. Caregiver D said s/he applied pressure but did not move Resident 5. Caregiver D said s/he did not know for sure what happened. S/he said on the previous rounds, Resident 5 was sleeping in his/her recliner and Resident 1 was sleeping in his/her bed across the hall. Caregiver D told Surveyor, "We can't ask [Resident 1], [s/he] doesn't understand. I assume [Resident 1] pulled [Resident 5] from the chair." Caregiver D told Surveyor Caregiver S slept "a good amount of shifts." Caregiver D said Caregiver S was sleeping before Resident 5's accident and went back to sleep after Resident 5's accident.

On 08/14/2024, Surveyor reviewed Caregiver S's employee file. S/he had a discipline form, dated 08/01/2024, indicating Caregiver S was terminated. The following reason was documented: "[Caregiver S] was found asleep, and snoring, on the couch in the Alpha living room at 3am, during [his/her] scheduled shift. [Caregiver S] was the assigned Med (medication) Passer during that shift. [Director of Nursing (DON) B] woke [Caregiver S] by patting [him/her] on the shoulder. [DON B] stated, '[Caregiver S], this is not an [sic] a sleeping position. You're being terminated, effective immediately. I'll walk you out.' [Caregiver S] did not speak. [S/he]

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gathered [his/her] belongings and walked out the rear entry of the building."

On 08/20/2024, Surveyor reviewed Resident 5's record.

Resident 5 was admitted to the facility on 02/08/2024. S/he had multiple diagnoses, including osteoarthritis and depression.

Resident 5's ISP, with a print date of 08/13/2024, indicated Resident 5 required some supervision and was able to make his/her needs known. His/her ISP read, in part: "Resident needs 1 staff member to provide stand by assistance with ambulation ... Resident needs stand by assistance from staff to transition between lying down, sitting, and standing positions ... Resident has the following interventions in place to reduce risk of serious injury from falls: 2 hour checks ... Resident bruises easily due to Warfarin use ... Resident has no difficulties communicating with others ...Resident sleeps through the night ..."

Resident 5 had an unwitnessed fall on 05/29/2024 at 12:38 a.m. Resident 5 was able to tell staff what happened. The incident report read: "Writer heard resident yell for help, writer went into resident room and found resident on the right side of resident's bed in fetal position. Resident said they [sic] fell and asked for assistance ... Resident was not in pain and was laughing about the situation ..."

The incident report, dated 07/31/2024 at 1:15 a.m., read, "Staff heard loud screams coming from resident room. Staff then ran to figure out what happened, when staff arrived they witnessed [Resident 1] standing over [Resident 5] on the ground. Staff then radioed for help. Staff

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noticed [Resident 5] lying in a weird position bleeding from [his/her] head and nose screaming in pain. [Resident 5] also was screaming to get [Resident 1] off of [him/her]. Staff removed [Resident 1] from the room and into [his/her] own room. Staff got towels an [sic] applied pressure to [his/her] wound on [his/her] head to stop the bleeding. Staff could not get vitals at the time because [Resident 5] was in too much pain. Staff then just waited for ems [sic] to arrive. Resident Statement [Resident 5] expressed [s/he] was in pain an [sic] that [Resident 1] made [him/her] get up. [Resident 5] became more incoherent as the conversation went on."

On 08/20/2024, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the facility on 04/20/2023. S/he had multiple diagnoses, including: dementia with behavioral disturbance, anxiety, insomnia, restlessness, and agitation.

Resident 1's individual service plan (ISP), with a print date of 08/13/2024, indicated Resident 1 required 24-hour supervision. His/her ISP read, in part, "Resident currently need [sic] moderate supervision for behaviors, about 3 times per week ... Resident's goals are to get support and receive assistance as needed in helping resident control his/her thoughts/feelings/actions. Resident needs staff to provided [sic] redirection and reassurance when behaviors occur ... Resident demonstrates signs of paranoia and hallucinations which require staff intervention. Behaviors include talking to people or animals that are not there ... Resident's goal is to get support and receive assistance as needed in helping control his/her thoughts/feelings/actions. Resident needs staff to provide redirection and reassurance when

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N 426	Continued From page 20 behaviors occur ... Resident rummages and searches through own belongings, other resident's belongings, and through facility's property. Resident needs staff to check room for items that do not belong to resident and return items to appropriate location ... Resident demonstrates verbal/physical aggressive behavior which requires staff intervention. Behaviors include hitting, punching, kicking, slapping, yelling, screaming, and inappropriate language ... Resident's goal is to get support and receive assistance as needed in helping control his/her thoughts/feelings/actions. Resident needs staff to provide redirection and reassurance when behaviors occur ... Resident demonstrates signs of anxiety/agitation which require staff intervention. Behaviors include pacing hallways, expressive of worries about [his/her] dogs and/or family, attempts at eloping, yelling, physical aggression, verbal aggression, and refusals of care ... Resident's goal is to get support and receive assistance as needed in helping control his/her thoughts/feelings/actions. Resident needs staff to provide redirection and reassurance when behaviors occur ... Resident wanders into other resident rooms or private areas and requires staff intervention ... Resident desires to have staff redirect him/her to public areas of the building if wandering into a private area ... Resident requires the following interventions and redirection strategies when behaviors arise short 1:1 visit, reduce loud or specific sounds, reduce overstimulation, offer snack, find [his/her] stuffed dog for [him/her], give resident space, administer PRN (as needed) medication, and/or provide resident with a task/activity ... Behaviors will be evaluated on a quarterly basis to ensure plan of care and redirection strategies align with positive response from resident."	N 426		

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N 426	Continued From page 21 From 01/2024 - 08/13/2024, Resident 1 had 11 resident to resident altercations. An incident report, dated 05/15/2024, read, in part, "[Resident 1] used [his/her] fist to hit 2nd resident on the back 5 - 6 times during the night." The investigation included the following: "Based on RHC (resident health coordinator) investigation, resident walked up to another resident and started to hit [him/her]. Describe action taken/measure initiated to reduce the possibility of future incidents: Action taken was to separate residents. [Resident 1] walked with staff to the Bistro." An incident report, dated 05/27/2024, read, in part, "[Resident 1] approached another resident that was sitting in a wheelchair in the hallway. [Resident 1] kicked this resident one time in their foot. Staff was able to intervene and walk [Resident 1] away from this resident." The investigation read, in part, "Based on RHC investigation, resident grabbed another resident's hand as [s/he] thought the resident owed [him/her] money. Describe action taken/measure initiated to reduce the possibility of future incidents: Residents were separated with no issues." An incident report, dated 05/29/2024, read, in part, "Resident walked up to another resident in the bistro and grabbed [his/her] fingers and started twisting them [sic] resident also stomped on [his/her] feet and kicked [his/her] ankles. The residents were separated. [Resident 1] is convinced the resident owes [him/her] some money." The investigation read, in part, "Based on RHC investigation, resident thought another resident stole money from [him/her]. Resident had medication changes recently and it is	N 426		

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believed to be a factor. Describe action taken/measure initiated to reduce the possibility of future incidents: Request sent to PCP (primary care provider) to re-prescribe resident's lorazepam as it was prehospital visit."

An incident report, dated 06/01/2024, read, in part, "The resident was in another resident's room, the owner of the room stated that they had told [Resident 1] to get out, and [Resident 1] started to hit [him/her]. They stated that [Resident 1] hit them approximately six times. The owner of the room stated [s/he] 'Pushed [him/her] out and locked the door.'" The investigation read, in part, "Based on RHC investigation, resident entered another resident's room and began to hit [him/her]. Describe action taken/measure initiated to reduce the possibility of future incidents: Based on RHC investigation, resident entered another resident's room and began to hit [him/her] [sic]."

An incident report, dated 06/02/2024, read, in part, "[Resident 1] hit another resident on [his/her] forearm, creating a red mark. [Resident 1] was yelling at the other resident about a dog. Residents were separated." The investigation read, in part, "Based on RHC investigation, resident became agitated and hit another resident. Describe action taken/measure initiated to reduce the possibility of future incidents: Resident was redirected with no issues."

An incident report, dated 06/07/2024, read, in part, "[Resident 1] grabbed another residents [sic] wrist and squeezed hardly [sic]. Code purple was called as [Resident 1] has been physically aggressive with this resident before. Residents were separated but [Resident 1] became very upset." The investigation read, in part: "Based on RHC investigation, resident walked up to another

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resident and grabbed [his/her] wrist. Describe action taken/measure initiated to reduce the possibility of future incidents: Residents were separated and no issues after."

An incident report, dated 06/08/2024, read, in part, "[Resident 1] was by another resident's room trying to open the door. The other resident got up from the dining room, walked over, and hit [Resident 1] across the face with [his/her] cane. [Resident 1] became very upset and kicked the other resident in the shin. Residents were separated ..." The investigation read, in part, "Based on RHC investigation, resident was [sic] entered another resident's room and that resident hit [him/her] with cane. Describe action taken/measure initiated to reduce the possibility of future incidents: Residents [sic] was assisted to [his/her] own room and helped get ready for bed."

An incident report, dated, 06/18/2024, read, in part, "Resident was heard yelling for help, staff followed the screams and saw another resident pushing [Resident 1] and [s/he] almost fell over. Staff noticed red marks on [Resident 1's] cheeks and [s/he] was crying. Staff went into the other residents [sic] room and inquired about what had happened. The other resident stated that [Resident 1] had come into [his/her] room and 'Messed it all up!' Resident stated [s/he] slapped 'the dickens?' out of [him/her] and 'That should teach [him/her] to stop coming in here!'" The investigation read, in part, "Based on RHC investigation, resident entered what [s/he] thought was [his/her] room. The resident that occupies the room became upset and hit [him/her]. Describe action taken/measure initiated to reduce the possibility of future incidents: Resident with POA (power of attorney) permission to [sic] was

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N 426	Continued From page 24 moved to opposite side of building." An incident report, dated 07/28/2024, read, in part, "[Resident 1] came over to [his/her] room pounding on the door so [s/he] answered and [Resident 1] said [s/he] was looking for a red coat of some sort and [resident] told [him/her] [s/he] did not have a red coat and that when [Resident 1] kneed [resident] in the abdomen and this was all unseen by staff but it came to the attention of stff [sic] when [staff] heard someone yelling call the cops and when [staff] walked over all [s/he] seen [sic] was [Resident 1] holding on to [resident] and [resident] tried to walk away and [Resident 1] fell on [his/her] butt." On 08/21/2024, Surveyor emailed Administrator A and asked if there were any increases in supervision or interventions added to Resident 1's ISP to prevent future altercations and prevent Resident 1 from entering other residents' rooms. On 08/21/2024, Administrator A replied, via email, in part, "I attached the Behavior Section of [his/her] ISP for your convenience. [Resident 1] admitted to us with these behaviors already existing, so interventions were put in place at that time. Subsequent interventions have been more medical and pharmaceutical in nature, as non-pharms are already in place, and [his/her] behaviors escalated due to an unsolicited med (medication) change after a visit to the ER (emergency room)." The provider did not add interventions or increase supervision when Resident 1 became more intrusive to other residents, by entering their rooms, and being physically aggressive to others. On 07/31/2024, staff found Resident 5 on the floor of Resident 5's room, bleeding. Resident 1	N 426		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE HALLIE MEMORY CARE	**4407 124TH STREET CHIPPEWA FALLS, WI 54729**

(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 426	Continued From page 25 was standing over the top of Resident 5 with one leg on each side of Resident 5. Resident 5 was sent to the emergency department and died that day from bleeding in the brain. The staff in charge, Caregiver S, was sleeping the night this incident occurred. The provider did not ensure adequate supervision was provided to keep Resident 1 from entering other residents' rooms and prevent resident to resident altercations.	N 426		