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	0018350	A. BUILDING: _____ B. WING _____	R-C 11/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR	**6300 67TH STREET KENOSHA, WI 53142**

(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 11/29/2024, Surveyor concluded a verification visit and complaint investigation at Parkside Manor. As a result, 7 deficient practices were identified. Two of 7 deficiencies were repeat violations (See SOD UJZS11 dated 05/16/2024). One complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. 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.	N 158		

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

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N 158	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, upon learning of an incident of alleged misconduct, the provider did not take immediate steps to ensure residents were protected from subsequent episodes of misconduct and abuse for 1 of 1 resident (Resident 17). On 10/11/2024 the provider became aware of an incident of alleged caregiver misconduct. Former Activity Director (AD) N and Administrator A took Resident 17's verbal report, alleging Caregiver M was the offender. The provider continued to allow Caregiver M to work and did not take steps to ensure residents were protected from subsequent episodes of misconduct. The provider did not start investigating the alleged misconduct until 10/18/2024, 7 days after the initial notification of alleged caregiver misconduct. Findings include: On 10/23/2023, the department received complaint information alleging caregiver was sexually inappropriate with residents. The provider continued to allow Caregiver M to work and did not take steps to ensure residents were protected from subsequent episodes of misconduct. On 11/05/2024, at 10:45 a.m., Surveyor reviewed misconduct incident report. The following was identified: On 10/18/2024, the department received a misconduct incident report (MIR) from Regional Vice President of Operations (RVPO) R. Under section titled, "Summary of incident",	N 158		

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RVPO R wrote, "[Activity Director (AD) N] was speaking with [Resident 17] on the memory care unit. [Resident 17] informed [AD N] that s/he had been sexually assaulted by a caregiver by putting 2 fingers inside his/her [orifice] per the residents [sic] words."

Attached to MIR, Surveyor observed hand-written and typed staff interviews. The following was identified:

- [AD N's] statement, dated 10/11/2024, outlined Resident 17's report. Resident 17 began to cry and begged AD N to believe 'what' s/he was going to report. Resident 17 stated that around the time s/he moved in, an employee came to him/her and told him/her that s/he needed to do an exam. Resident 17 stated s/he thought it was normal and the employee told Resident 17 to pull his/her pants down. Resident 17 complied, lowering his/her pants to his/her knees. S/He stated the employee then inserted his/her fingers into his/her orifice. Resident 17 said her orifice was still very sore. Resident 17 stated s/he could see him/her in his/her mind. Resident 17 was very distraught and crying and worried s/he did something wrong. Resident 17 stated it's been, "eating at him/her." S/He begged AD N to please not make him/her leave.

Surveyor observed a text message screen shot from Caregiver Y. The text message read, "On Thursday October 17, 2024, [Caregiver Y] was given [sic] [Resident 17] his/her medicine. When [Caregiver Y] was about to give [Resident 17] his/her insulin, [Resident 17] saw [Caregiver M] come out of the break room, [Resident 17] said what is s/he doing here? [Caregiver Y] said who? Then [Caregiver Y] looked and saw [Caregiver M]. [Caregiver Y] said what's wrong [sic] then

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[Resident 17] started crying [Caregiver Y] said you can talk to me [sic] [Resident 17] told [Caregiver Y] that [Caregiver M] said s/he needs to check him/her and s/he put his/her finger in his/her [orifice]. [Resident 17] started shaking and is very scared. Every time s/he see [sic] him/her. Signed, [Caregiver Y] 10/17/2024."

On 11/07/2025 at approximately 10:15 a.m., Surveyor reviewed current staff roster and observed [Caregiver M] with a start date of 04/09/2024.

Adult Protective Services (APS) Report

On 10/17/2024, APS G interviewed staff, who disclosed Administration was not responding appropriately to Resident 17's allegation. The staff indicated Resident 17 provided his/her statement of abuse to Administration and another staff member. The staff who was named in the complaint was moved to reception. The reported staff continued to be in the building after the report and Resident 17 continued to see him/her.

On 10/17/2024, APS G interviewed Resident 17 about concerns of abuse at the facility. Resident 17 stated the [fe/male] caregiver said to him/her, "I need to check you." Then proceeded to put his/her fingers in his/her [orifice]."

On 11/06/2024, APS G concluded the investigation. His/Her documentation included the identification of Caregiver M. APS G interviewed staff, who had witnessed Caregiver M sticking his/her hand into other residents' private areas, in common living spaces, such as the dining room. Interviewed staff stated that these concerns were reported to Administration. According to staff, Caregiver M was still working at the facility, but

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s/he had been reassigned to reception. When APS G interviewed Administration, they stated an investigation was in progress and they were still taking statements. Administration stated they only completed a Department of Health Services (DHS) state report if they believed something occurred. When APS G requested findings and statements on 10/17/2024, Administration refused and stated they were confidential.

Resident 17 had a previous health care power of attorney (HCPOA) document that was invalid due to witness signing on different dates. A copy of the updated HCPOA was in his/her file. APS G wrote, "Confirmed that client had recently been assessed by her doctor and she passed memory screens and remains her own person."

Caregiver M's October 2024 scheduled work hours

On 11/15/2024 at 3:15 p.m., Surveyor reviewed facility's punch source report, dated 09/30/2024-11/01/2024. Caregiver M worked the following dates and hours:

-10/04/2024: 12:00 p.m.- 5:40 p.m.
-10/04/2024: 6:10 p.m.- 10:17 p.m.
-10/07/2024: 5:57 p.m.- 10:00 p.m.
-10/11/2024: 8:30 a.m.- 2:08 p.m.
-10/12/2024: 1:59 p.m.- 5:26 p.m.
-10/12/2024: 5:53 p.m.-10:01 p.m.
-10/13/2024: 8:24 a.m.- 6:04 p.m.
-10/13/2024: 6:34 p.m.-10:05 p.m.
-10/15/2024: 1:56 p.m.- 6:24 p.m.
-10/15/2024: 6:49 p.m.-10:01 p.m.
-10/16/2024: 11:00 a.m.- 7:00 p.m.
-10/16/2024: 7:30 p.m.-10:10 p.m.
-10/17/2024: 8:30 a.m.- 5:14 p.m.

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Upon learning of an incident of alleged misconduct on 10/11/2024, the provider did not take immediate steps to ensure residents were protected from subsequent episodes of misconduct and abuse. Caregiver M continued to work shifts in the building.

Interviews

On 11/07/2024 at 3:45 p.m., Surveyor interviewed Administrator A, Wellness Director (WD) P, and Associate Administrator (AA) O. Administrator A stated s/he interviewed Resident 17 the same day of the reported incident. Resident 17 was unable to provide clear details like who, what and when the assault occurred.

Resident 17 described a person who was tall, with white hair and glasses. Surveyor confirmed the interview between Resident 17 and Administrator A occurred at 4:00 p.m. Administrator A acknowledged that time of day was not the best time to do an interview with someone who has a memory impairment diagnosis. Administrator A stated s/he called the Regional Vice President (RVP) Z and started his/her investigation. Administrator A stated Caregiver M was put at the front desk during the investigation.

On 11/08/2024 at 9:05 a.m., Surveyor interviewed Caregiver I, who stated Administrator A typed up caregivers' statements after Adult Protective Services (APS) was in the building. Caregiver I, stated, "S/He typed them up and dated them and had us just sign them."

On 11/08/2024 at 9:40 a.m., Surveyor interviewed Cook Q, who stated, Caregiver M walked up to Resident 16, who was walking with a walker in

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N 158	Continued From page 6 the common area. From behind, Caregiver M pulled the back of Resident 16's pants out, stuck his/her hands down the back of the Resident 16's pants to see if s/he was wet. Resident 16 started screaming at Caregiver M and started chasing him/her. Cook Q stated s/he reported the incident to Administrator A. On 11/08/2024 at 3:30 p.m., Surveyor interviewed AD N, who stated Resident 17 reported a sexual assault to him/her on 10/11/2024. Resident 17 was in AD N's office crying. AD N called Administrator A into the office to listen to Resident 17. When s/he was done with his/her report, Administrator A asked AD N to write it up. I provided Administrator A with the letter. S/He stated s/he would take care of it. AD N also placed a telephone call to RCD F to report the sexual assault. RCD F stated, "They would take care of it. I felt obligated to bring it forward as a mandatory reporter." AD N stated Resident 17's memory was not that bad.	N 158		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these	N 310		

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N 310	Continued From page 7 services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not ensure an admission agreement was signed and dated before or at the time of admission for 1 of 1 resident reviewed (Resident 17). Findings include: On 11/07/2024 at 2:25 p.m., Surveyor reviewed Resident 17's record. The following was identified: Resident 17 was admitted to the facility on 09/30/2024, with diagnoses including unspecified dementia, without behavioral disturbance,	N 310		

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N 310	Continued From page 8 psychotic disturbance, mood disturbance and anxiety, depressive disorder, and type 2 diabetes. Resident 17 had an activated healthcare power of attorney (AHCPOA). On 11/07/2024 at 2:45 p.m., Surveyor requested Resident 5's signed admission agreement from Administrator A. Administrator A told Surveyor that they couldn't find Resident 17's admission agreement. Administrator A stated s/he would look for the folder with the requested information and send to Surveyor no later than 11/08/2024 at 5:00 p.m. As of 11/08/2024 at 5:00 p.m., no further information had been received.	N 310		
{N 401}	83.37(1)(b) Medication label permanently attached. Medications. Prescription medications shall come from a licensed pharmacy or a physician and shall have a label permanently attached to the outside of the container. Over-the-counter medications maintained in the manufacturer ' s container shall be labeled with the resident ' s name. Over-the-counter medications not maintained in the manufacturer ' s container shall be labeled by a pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medications were labeled to ensure proper and safe usage in 1 of 2 medication carts. Resident 18's insulin pen was found without a pharmacy label. This is a repeat deficiency. See Statement of	{N 401}		

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{N 401}	Continued From page 9 Deficiency UJZS11, dated 05/16/2024. Findings include: On 11/25/2024 at 2:25 p.m., Surveyor reviewed Resident 18's record. The following was identified: Resident 18 was admitted to the facility on 10/21/2024, with diagnoses including deep vein thrombosis and diabetes. On 11/07/2023, at 8:55 a.m., Surveyor observed the medication carts. Surveyor observed the following medication located in the medication carts without a label: Resident 18 - Glargaine-YFGN (Lantus) 100-unit insulin pen On 11/07/2024, at 9:15 a.m., Surveyor interviewed Caregiver X, who confirmed Resident 18's medications should have included prescriptive information. Caregiver X stated, "[Resident 18] moved in about three weeks ago. This is how his/her medicine came to us." On 11/07/2024 at 4:00 p.m., Surveyor interviewed Administrator A, Wellness Director (WD) P, and Associate Administrator (AA) O. WD P stated Resident 18 was using up the medication s/he moved in with.	{N 401}		
{N 406}	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued,	{N 406}		

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{N 406}	Continued From page 10 the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on observation and interview, the provider did not establish an effective procedure for handling medications when a resident was discharged from the facility. One of 1 resident (Resident 23) had medications left in the medication cart after they were discharged. This is a repeat deficiency. See Statement of Deficiency UJZS11, dated 05/16/2024. Findings include: The provider is licensed to care for up to 74 residents in the client groups of terminally ill, physically disabled, irreversible dementia/Alzheimer's and advanced aged.	{N 406}		

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{N 406}	Continued From page 11 On 11/07/2024, at 9:45 a.m., Surveyor toured the facility and observed the following: Surveyor observed two, prepackaged rolls of pills dated from 10/24/2024 to 11/06/2024, in the medication cart. The prepackaged rolls of pills belonged to Resident 23. The prepackaged rolls contained: -Calcium carbonate 600 milligram (mg) tablets -Multivitamin -Vitamin B12 1,00 microgram (mcg) -Vitamin D3 50 mcg -Preservision ARENDS 14,320-226-200 units-mg-unit -Divalproex sodium extended release (ER) at bedtime (*HD*) 500 mg (Depakote) -Fenofibrate 48 mg -Sertraline hydrochloride (HCL) (Zoloft) 100 mg -Seroquel 25 mg -Losartan potassium 100 mg -Momentane HCL (Namenda) 10 mg -Folic acid 1 mg -Tamsulosin HCL 0.4 mg (Flomax) -Donepezil HCL 10 mg (Aricept) -Hydrochlorothiazide 12.5 mg -Lorestan Potassium 100 mg -Eliquis 5 mg -Acetaminophen 500 mg On 11/07/2024, at 9:45 a.m., Surveyor interviewed Caregiver I, who stated Resident 23 died within the past two weeks. His/Her family came and collected all his/her things. Caregiver I confirmed Resident 23 had medication in the medication cart. On 11/07/2024 at 9:48 a.m., Surveyor interviewed Medication Passer H, who confirmed Resident 23	{N 406}		

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{N 406}	Continued From page 12 died and was discharged from the facility on 10/31/2024. On 11/07/2024, at 10:15 a.m., Surveyor reviewed the resident roster. The resident roster identified Resident 23 was not living at the facility. On 11/07/2024 at 4:50 p.m., Surveyor interviewed Administrator A, Wellness Director (WD) P and Associate Administrator (AA) O. Administrator A stated that Resident 23 was on hospice. Administrator A believed hospice would collect Resident 23's medication and destroy it when s/he died. Administrator A stated, "We called our pharmacy to find out who collected the outdated medication. I guess that was not clear between hospice and the pharmacy."	{N 406}		
N 444	83.40 Oxygen storage. Oxygen storage. Oxygen storage shall be in an area that is well ventilated and safe from environmental hazards, tampering, or the chance of accidental damage to the valve stem. If oxygen cylinders are in use, oxygen cylinders shall be secured in an upright position. If stored upright, cylinders must be secured. If stored horizontally, cylinders shall be on a level surface where they will remain stationary. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure oxygen was secured when stored upright in resident room. Resident 24 had one, 198-liter oxygen cylinder stored upright, on the floor and not secured. Findings include:	N 444		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR	6300 67TH STREET KENOSHA, WI 53142

(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 444	Continued From page 13 On 11/07/2024, at 10:45 a.m., Surveyor observed Resident 24's room. One, 198-liter oxygen cylinder was stored upright, on the floor and not secured, in Resident 24's closet. On 11/07/2024, at 10:50 a.m., Surveyor interviewed Resident 7, who stated s/he kept his/her oxygen in his/her room as spares. The oxygen gets delivered right to his/her room. S/He explained it was a convenience. Resident 24 indicated only the large cylinder had a secure stand, the other one did not. On 11/07/2024, at 4:25 p.m., Surveyor interviewed Administrator A, who stated the medical technicians knew oxygen should be stored upright and secure. "We will need to re-educate them."	N 444		
Y3234	50.09(1)(e) Treatment (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: (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.	Y3234		

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Y3234	Continued From page 14	Y3234		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 5 of 5 residents were treated with courtesy, respect and full recognition of the resident's dignity and individuality.

Resident 16, Resident 19, Resident 20, Resident 21, and Resident 22 were not treated with courtesy and respect. Staff inappropriately touched them, in common areas, in a manner that resulted in their dignity and individuality being violated.

Findings include:

On 10/23/2024, the department received complaint information alleging residents were not treated with dignity and respect. Staff was reportedly checking residents for incontinence in the memory care unit by putting his/her hand in their private area, in the dining room, stating, "S/He needed to check them to see if they were wet."

On 11/05/2024, at 10:45 a.m., Surveyor reviewed misconduct incident report. The following was identified:

On 10/18/2024, the department received a misconduct incident report (MIR) from Regional Vice President of Operations (RVPO) R.

Under section titled summary of incident, RVPO R wrote, "[Activity Director N] was speaking with [Resident 17] on the memory care unit. [Resident 17] informed [Activity Director N] that s/he had been sexually assaulted by a [male/female] caregiver by putting 2 fingers inside his/her

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Y3234	Continued From page 15 [orifice] per the residents [sic] words." Attached to MIR, Surveyor observed typed and hand-written staff interviews. The following was identified: - Caregiver I's statement, dated 10/17/2024, read, "[Caregiver I] stated that s/he only heard about the incident with [Caregiver M] that morning. S/He also stated that s/he saw [Caregiver M] check a resident brief in a common area but didn't report it. Care staff just spoke about it amongst themselves. [Administrator A] asked if [Caregiver I] thought it was sexual in nature, s/he said no [sic] it should have been done privately." -Medication Passer H's statement, dated 10/17/2024, read, "[Administrator A] asked [Medication Passer (MedPass) H] if s/he had ever seen [Caregiver M] act inappropriately toward another resident. S/He said s/he saw [Caregiver M] check, a resident in a common area. [Administrator A] asked [MedPass H] if s/he felt it was sexual in nature [sic] s/he said no but s/he shouldn't have done it in common area." Adult Protective Services (APS) Report On 11/06/2024 at 4:15 p.m., Surveyor reviewed Adult Protective Services (APS) G's report, dated 11/06/2024. The following was identified: On 10/17/2024, APS G interviewed facility staff, who disclosed that they were concerned Administration was not responding appropriately to Resident 17's allegation. There had been three to four other complaints regarding Caregiver M. Caregiver M had been witnessed in common areas of the memory care facility stating, "I have to check you" to residents, some who may have	Y3234		

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Y3234	Continued From page 16	Y3234		

been nonverbal and/or incapacitated. Witnesses observed Caregiver M put his/her hand into resident's incontinence brief and private area right in the common area.

On 10/17/2024, APS G requested investigation notes from Administrator A, who stated the documentation was confidential and s/he refused to provide any documentation to APS G.

On 11/06/2024, APS G concluded the investigation. Resident 17 reported a sexual assault, and the facility did not respond or take their resident's report seriously. Caregiver M was still working at the facility, but s/he had been reassigned to reception. On 11/06/2024, APS G substantiated his/her case findings of abuse.

On 11/06/2024, APS G substantiated his/her case findings of abuse.

Interviews

Resident 16
On 11/08/2024 at 9:05 a.m., Surveyor interviewed Caregiver I, who stated s/he witnessed Caregiver M inappropriately touch Resident 16. Caregiver I stated Resident 16 was walking with his/her walker through the common activity area. Caregiver M walked up behind him/her, put his/her hands inside the backside of his/her briefs and stated, "You are okay." Surveyor asked Caregiver I if s/he knew why Caregiver M did that. Caregiver I reported, "S/He was checking if [Resident 16] was wet or dry and needed to be toileted. Right out in the common area."

On 11/08/2024 at 9:40 a.m., Surveyor interviewed Cook Q, who stated, Caregiver M walked up to Resident 16, who was walking with a walker in

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Y3234	Continued From page 17 the common area. From behind, s/he pulled the back of Resident 16's pants out, stuck his/her hands down the back of the Resident 16's pants to see if s/he was wet. Resident 16 started screaming at Caregiver M and started chasing him/her. Cook Q stated s/he reported the incident to Administrator A. Caregiver M was suspended to the front desk but came back to the floor. On 11/08/2024 at 2:30 p.m., Surveyor interviewed Medication Passer (MedPass) H, who stated s/he witnessed Caregiver M inappropriately touch Resident 16. Caregiver M walked up behind him/her in the middle of the dining room, put his/her hands inside the backside of Resident 16's briefs. There were other residents and staff around because it was shift-change. Resident 19. Resident 20 and Resident 21 On 11/08/2024 at 9:05 a.m., Surveyor interviewed Caregiver I, who reported observing Caregiver M putting his/her hands down the front of Resident 19's, Resident 20's, and Resident 21's pants to see if they were wet or dry and move on. Resident 22 On 11/08/2024 at 9:40 a.m., Surveyor interviewed Cook Q, who stated, former Resident 22 reported an unidentified person coming into bed and attacking him/her. Administrator A dismissed it as dementia. Resident 22 refused to eat after report and passed away shortly after.	Y3234		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based	Y3244		

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Y3244	Continued From page 18 residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure Resident 17 received adequate and appropriate care within the capacity of the facility. Resident 17's physician documentation, faxed to pharmacy from facility prior to his/her move in, indicated how to apply Resident 17's medication. It read, "Place 2 g (grams) into the [orifice] nightly. Place a large pea sized amount into the [orifice] nightly for two weeks and then three times a week after that. Do not use applicator." The facility staff had been using the applicator to apply the medication. Findings include: On 10/23/2024, the department received complaint information alleging staff inserted fingers into resident's [orifice], in resident's private	Y3244		

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Y3244	Continued From page 19	Y3244		

area.

Resident 17 was admitted to the facility on 09/30/2024, with diagnoses including unspecified dementia, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, depressive disorder, and type 2 diabetes. Resident 17 had an activated healthcare power of attorney (AHCPOA).

Record Review

On 11/22/2024 at approximately 10:30 a.m., Surveyor reviewed facility misconduct incident report. The following was identified:

On 10/18/2024, the department received a misconduct incident report from Regional Vice President of Operations (RVPO) R.

Under section titled, 'Explain what steps the entity took upon learning of the incident to protect the affected person and others from further potential misconduct', Surveyor read, "Explained [Resident 17] does get an [orifice] suppository three times a week which may explain why s/he feels someone has 'assaulted' him/her."

Surveyor reviewed hand-written note, dated 10/11/2024, by Caregiver U. The note read, "[Resident 17] gets a suppository three days a week."

On 11/07/2025 at approximately 3:45 p.m., Surveyor reviewed Resident 17's office visit note, dated 08/20/2024, with physician (MD) V. Under medications being taken, it read, "Place 2 g (grams) into the [orifice] nightly. Place a large pea sized amount into the [orifice] nightly for two weeks and then three times a week after that. Do

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Y3244	Continued From page 20 not use applicator." On 11/08/2025 at approximately 10:45 a.m., Surveyor reviewed Resident 17's October 2024 medication administration record (MAR). Resident 17 had an order for Estradiol 0.01% milligram (mg) cream, with a start date of 09/27/2024. Resident 17's MAR read, "Apply 2 grams of estradiol [to orifice] at bedtime three times a week on Monday, Wednesday and Friday as directed." Observation On 11/07/2024 at 4:08 p.m., Surveyor toured the medication area with Caregiver U. Surveyor observed Resident 17's Estradiol 0.01% milligram (mg) cream in a clear bag with a clear plastic applicator, approximately 4 inches long. The medication was prescribed by physician (MD) V and dated 09/26/2024. Surveyor observed, what appeared to be, a used applicator in the plastic bag with the Estradiol cream. Surveyor asked Caregiver U if staff use the applicator to apply the cream. Caregiver U stated, "It looks like it." Interviews On 11/07/2024 at 3:55 p.m., Surveyor interviewed Caregiver U, who confirmed s/he gave Resident 17 an [orifice] suppository three times a week, in the evening. On 11/07/2024 at 4:00 p.m., Surveyor interviewed Administrator A, Wellness Director (WD) P and Associate Administrator (AA) O. WD P stated Resident 17 received a [orifice] suppository three times a week, in the evening. On 11/08/2024 at 10:00 a.m., Surveyor	Y3244		

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Y3244	Continued From page 21 interviewed Nurse (RN) K, who stated Resident 17 had an [orifice] cream. It typically came with an applicator; however, the physician orders required the staff to put it on topically. The MAR did not indicate an applicator was to be used. RN K stated Caregiver M was not a medication passer and would not have had anything to do with Resident 17's [orifice] cream. On 11/27/2024 at 2:20 p.m., Surveyor interviewed Pharmacist (Pharm) W, who stated the pharmacy received a signed medication list, dated 08/20/2024, with MD V's signature. Pharm W confirmed Resident 17's order for Estradiol 0.01% milligram (mg) cream read, "Apply 2 grams of estradiol [to orifice] at bedtime three times a week on Monday, Wednesday and Friday as directed." Pharm W stated, "I do see here on the original physician's order on 08/20/2024 that it says, 'Do not use an applicator'. That language did not translate to our instructions on the MAR."	Y3244		