STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	C 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 05/29/2024, Surveyor conducted a 6 complaint investigation at Rolling Meadows of Strum. Data collection continued through 07/09/2024. Four of 6 complaints were substantiated. Seven deficiencies were identified. Five of 7 deficiencies were repeat violations. See Statement of Deficiency (SOD) LHMG11, dated 10/05/2021, SOD ZY4711, dated 12/07/2021, SOD ZY4712, dated 06/22/2022, SOD J0MI11, dated 09/09/2022, and SOD ZY4713, dated 02/09/2023). Census: 17	N 000		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and observation, the licensee did not ensure the community based residential facility (CBRF) and its operation complied with all laws governing the CBRF. This had the potential to affect 17 of the 17 residents that resided at the facility. This is a repeat deficiency. See Statement of Deficiency (SOD) ZY4713, dated 02/09/2023, SOD ZY4714, dated 07/28/2023, and SOD ZY4715, dated 02/23/2024.	N 196		

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

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N 196	Continued From page 1 Findings include: The facility is licensed to serve up to 19 residents in the following client groups: physically disabled, terminally ill, advanced aged, and irreversible dementia/Alzheimer's disease. On 05/29/2024, Surveyor conducted a 6-complaint investigation at Rolling Meadows of Strum. On 05/29/2024, Surveyor reviewed department records for Rolling Meadows of Strum, licensed on 10/01/2021. Since initial licensure, the facility has had 16 substantiated complaints resulting in 44 deficiencies, and multiple repeat deficiencies issued. The following information was reviewed: LHMG11, dated 10/05/2021. Four deficiencies were identified. Two of 3 complaints were substantiated. 1. 83.12(4)(c) Reporting Incidents With Serious Injury 2. 83.31(2) Emergency Or Temporary Transfer 3. 83.32(3)(h) Rights Of Residents: Receive Medication 4. 83.47(1)(c) Safety Requirements: No Safe Evacuation ZY4711, dated 12/07/2021. Two deficiencies were identified. Two of 3 complaints were substantiated. 1. 83.32(3)(h) Rights Of Residents: Receive Medication 2. 83.32(3)(n) Rights Of Residents: Safe	N 196		

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N 196	Continued From page 2 Environment J0MI11, dated 09/09/2022. One deficiency was identified. Two of 5 complaints were substantiated. 1. 83.32(3)(h) Rights Of Residents: Receive Medication ZY4712, dated 06/22/2022. Six deficiencies were identified. Three of 8 complaints were substantiated. There was one repeat violation (see SOD ZY4711, dated 12/07/2021). 1. 83.17(2)(a) Employees Screened For Communicable Disease 2. 83.32(3)(h) Rights Of Residents: Receive Medication 3. 83.38(1)(g) Health Monitoring 4. 83.45(1)(d) Hazards 5. 83.55(6)(b) Bath And Toilet Areas: Water Temperature 6. 50.065(2)(bm) Out Of State Background Checks ZY4713, dated 02/10/2023. Seven deficiencies were identified. One of 3 complaints was substantiated. Three of 7 deficiencies were repeat violations (see SOD LHMG11, dated 10/05/2021, SOD ZY4711, dated 12/07/2021, SOD ZY4712, dated 06/22/2022, and SOD J0MI11, dated 09/09/2022). 1. 83.12(2)(a) Caregiver: Investigating Abuse Neglect 2. 83.12(5)(a) Notification: Incident, Injury,	N 196		

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N 196	Continued From page 3	N 196		

Changes.
3. 83.14(2)(a) Licensee Ensures Facility Complies With Laws
4. 83.32(3)(h) Rights Of Residents: Receive Medication
5. 83.32(3)(i) Rights Of Residents: Adequate Treatment
6. 83.55(6)(b) Bath And Toilet Areas: Water Temperature
7. 50.065(2)(bm) Out Of State Background Checks

ZY4714, dated 07/28/2023.

Seven deficiencies were identified. One of 1 complaints was substantiated. Four of the 7 deficiencies were repeat violations (see SOD LHMG11, dated 10/05/2021, SOD ZY4711, dated 12/07/2021, SOD ZY4712, dated 06/22/2022, SOD J0MI11, dated 09/09/2022, and SOD ZY4713, dated 02/09/2023).

1. 83.12(2)(a) Caregiver: Investigating Abuse Neglect
2. 83.14(2)(a) Licensee Ensures Facility Complies With Laws
3. 83.14(2)(j) Not Permit A Condition Of Substantial Risk
4. 83.32(3)(h) Rights Of Residents: Receive Medication
5. 83.32(3)(n) Rights Of Residents: Safe Environment
6. 83.35(3)(a) Comprehensive Individualized Service Plan
7. 83.38(1)(a) Personal Care

ZY4715, dated 02/23/2024.

Ten deficiencies were identified. One of 1 complaint was substantiated. Four of the 10

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N 196	Continued From page 4 deficiencies were repeat violations (see SOD LHMG11, dated 10/05/2021, SOD ZY4713, dated 02/09/2023, SOD ZY4714, dated 07/28/2023). 1. 83.12(2)(a) Caregiver: Investigating Abuse Neglect 2. 83.12(4)(c) Reporting Incidents With Serious Injury 3. 83.14(2)(a) Licensee Ensures Facility Complies With Laws 4. 83.20(2)(a)-(d) Department-Approved Training Courses 5. 83.21(1)-(3) All Employee Training 6. 83.35(3)(a) Comprehensive Individualized Service Plan 7. 83.35(4) Resident Satisfaction Evaluation 8. 83.38(1)(k) Transportation 9. 83.40 Oxygen Storage 10. 83.47(2)(d) Fire Drills UWFF11, dated 07/09/2024. Seven deficiencies were identified. Four of 6 complaints were substantiated. Five of the 7 deficiencies were repeat violations (see SOD LHMG11, dated 10/05/2021; ZY4711, dated 12/07/2021; ZY4712, dated 06/22/2022; J0MI11, dated 09/09/2022; ZY4713, dated 02/09/2023; ZY4714, dated 07/28/2023; and ZY4715, dated 02/23/2024. 1. 83.14(2)(a) Licensee Ensures Facility Complies With Laws 2. 83.15(3)(a) Administrator Shall Supervise Daily Operation 3. 83.28(7) Advanced Directives 4. 83.32(3)(h) Rights Of Residents: Receive Medication 5. 83.32(3)(i) Rights Of Residents: Adequate Treatment	N 196		

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N 196	Continued From page 5 6. 83.35(3)(a) Comprehensive Individualized Service Plan 7. 83.38(1)(g) Health Monitoring On 07/09/2024 at 2:30 PM, Surveyor discussed the above concerns with Licensee A, Administrator B, and Registered Nurse (RN) J via phone during an exit conference. RN J stated they cannot supervise residents 1:1 with staffing and cannot control how staff react in situations. RN J stated they had been doing a lot of education with staff on following the policies and procedures in place. Administrator B stated it was staff's responsibility to familiarize themselves with resident records, know their code status, etc. Licensee A, Administrator B, and RN J acknowledged the above concerns and would be working toward compliance immediately. The licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF when all deficiencies were not corrected. Cross References: N0196 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0214 83.15(3)(a) Administrator Shall Supervise Daily Operation N0306 83.28(7) Advanced Directives N0352 83.32(3)(h) Rights Of Residents: Receive Medication N0353 83.32(3)(i) Rights Of Residents: Adequate Treatment N0386 83.35(3)(a) Comprehensive Individualized Service Plan N0431 83.38(1)(g) Health Monitoring	N 196		
N 214	83.15(3)(a) Administrator shall supervise daily operation	N 214		

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N 214	Continued From page 6	N 214		

The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected.

This Rule is not met as evidenced by:
Based on record review and interview, the administrator did not supervise the daily operations, including supervision to ensure proper care and services, that the residents' health and safety were protected and promoted, and that residents' rights were respected when Administrator B was on-call 04/09/2024 and did not answer his/her phone when Caregiver D attempted to call for Resident 1's change in condition.

Findings include:

On 03/19/2024, the Department received a complaint alleging resident care needs were not being met by the provider.

On 04/10/2024 and 04/12/2024, the Department received 2 complaints related to the provider's response to changes in a resident's condition and lack of administrator oversight.

The facility is licensed to serve up to 19 residents from the following client groups: irreversible

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N 214	Continued From page 7 dementia/Alzheimer's, terminally ill, physically disabled and/or advanced age. On 05/29/2024, Surveyor conducted a 6-complaint investigation. Based on nterviews and record reviews, Surveyor substantiated 4 of the 6 complaints and 5 of the 7 deficiencies identified were repeat violations. The following 7 deficiencies were identified: 83.14(2)(a) Licensee Ensures Facility Complies With Laws 83.15(3)(a) Administrator Shall Supervise Daily Operation 83.28(7) Advanced Directives 83.32(3)(h) Rights Of Residents: Receive Medication 83.32(3)(i) Rights Of Residents: Adequate Treatment 83.35(3)(a) Comprehensive Individualized Service Plan 83.38(1)(g) Health Monitoring Health Monitoring The administrator did not ensure Resident 1's health was monitored when Resident 1's skin was vulnerable and prone to skin breakdown. Resident 1 sustained a scrape to his/her right toes on 01/28/2024 that were not consistently monitored or assessed by facility staff. The wounds developed into cellulitis and on 03/02/2024, the toes were amputated. The provider assumed the home health agency was monitoring Resident 1's skin. Home health was not notified until 02/26/2024 of Resident 1's toe wounds when bone already showed, and cellulitis had developed. Prompt and Adequate Treatment	N 214		

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N 214	Continued From page 8	N 214		

The administrator did not ensure Resident 1 received prompt and adequate treatment on 04/09/2024, when s/he experienced a change in condition that led to his/her death. Caregiver D observed Resident 1 take his/her last breath at approximately 2:08 AM and emergency medical services (EMS) was not called until 2:43 AM.

The facility phone call log indicated the following on 04/09/2024:

-Administrator B had an initial phone call from staff at 2:18 AM. Administrator B declined a phone call at 2:41 AM. -Administrator B had at least 2 additional phone calls from staff.
-AA C had an initial phone call from staff at 2:19 AM and another call at 2:30 AM.
-Licensee A had an initial phone call from staff at 2:25 AM.
-The emergency services were called initially by staff at 2:35 AM.

On 05/29/2024 at 11:50 AM, Surveyor interviewed Assistant Administrator (AA) C and asked who was on call that shift. AA C stated s/he could not remember if Administrator B or s/he was on call that shift but had his/her phone on vibrate due to not wanting his/her child to be awakened. AA C stated s/he did not hear the phone when Caregiver D called twice that morning. AA C stated Administrator B was aware of Resident 1's condition and was present at the facility on 04/08/2024. AA C stated Caregiver N had concerns on 04/08/2024 during his/her evening shift, but never notified management or charted in the staff progress notes.

On 05/29/2024 at 12:51 PM, Surveyor interviewed Administrator B. Administrator B

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N 214	Continued From page 9	N 214		

stated Licensee A was backup for staff to call if AA C or s/he could not be reached. Licensee A was the fifth call Caregiver D made and Licensee A directed Caregiver D to call Guardian E and 911. Caregiver D ended up calling Guardian E before 911. Administrator B stated staff were responsible for familiarizing themselves with each resident's code status. Administrator B stated that on 04/08/2024, Resident 1 was doing well. Administrator B stated Caregiver N had never informed him/her of Resident 1's change in condition on the evening of 04/08/2024.

On 07/09/2024 at 2:30 PM, Surveyor interviewed Licensee A, Administrator B, and Registered Nurse (RN) J. RN J stated s/he assumed home health was supposed to do a full head to toe assessment and check on residents' skin integrity. RN J stated they had been relying on home health to look at Resident 1's skin and felt there was miscommunication. RN J stated s/he was unsure when home health was actually notified and when they took over wound care for Resident 1. Surveyor asked who oversaw updating any changes in services to a resident's record and notifying staff. Administrator B stated it was his/her responsibility. Administrator B stated that if staff would have informed him/her about Resident 1's change in condition, s/he would have been able to educate staff on what to do in the situation.

Administrator B did not supervise the daily operations to ensure proper care and services, that the residents' health and safety were protected and promoted, and that residents' rights were respected, when Administrator B did not monitor Resident 1's wound on his/her toe. Resident 1 developed osteomyelitis and had 2 toes amputated. Administrator B was on call

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N 214	Continued From page 10 04/09/2024, and did not answer his/her phone when Caregiver D attempted to call for Resident 1's change in condition, which caused a delay in 911 being called. Resident died on 04/09/2024.	N 214		
N 306	83.28(7) Advanced directives. Advanced directives. At the time of admission, the CBRF shall determine if the resident has executed an advanced directive. An advanced directive describes, in writing, the choices about treatments the resident may or may not want and about how health care decisions should be made for the resident if the resident becomes incapacitated and cannot express their wishes. A copy of the document shall be maintained in the resident record as required under s. HFS 83.42(1)(s). A CBRF may not require an advanced directive as a condition of admission or as a condition of receiving any health care service. An advanced directive may be a living will, power of attorney for health care, or a do-not-resuscitate order under chs. 154 or 155, Stats., or other authority as recognized by the courts of this state. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 2's advance directive/Do Not Resuscitate (DNR) order or bracelet were available so emergency personnel could be aware of their wishes in imminent death situations. Findings include: On 04/03/2024, the Department received a complaint alleging advance directive/DNR orders	N 306		

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N 306	Continued From page 11 were not available to emergency personnel. The facility is licensed to serve up to 19 residents from the following client groups: irreversible dementia/Alzheimer's, terminally ill, physically disabled and/or advanced age. On 05/29/2024, Surveyor requested Resident 2's records. Resident 2 was admitted to the facility on 01/04/2024. Resident 2 had multiple diagnoses, including: type 2 diabetes mellitus, chronic kidney disease, diabetic neuropathy, obstructive sleep apnea, morbid obesity, and paroxysmal atrial fibrillation. Resident 2 had an activated power of attorney for healthcare (POAHC) and the face sheet indicated in red under his/her name that Resident 2 was a DNR (do not resuscitate). Surveyor reviewed staff progress notes and found the following: 04/02/2024 at 6:45 AM written by Caregiver P - " ...Writer then gave them (emergency medical technicians [EMTs]) a facesheet [sic] and the discharge paperwork that they requested after seeing [Resident 2's] hospital bracelet. Then they asked for [Resident 2's] DNR legal paperwork and writer informed them that as far as writer knows [s/he] is a full code but writer went and checked. In [electronic record] it states [s/he] is a fullcode [sic], on [his/her] discharge paperwork from [his/her] previous facility states [s/he] is a DNR but we do not have any legal paperwork stating that [s/he] is a DNR even though [s/he] currently wears a DNR bracelet. Writer informed [EMTs] that we do not currently have any legal paperwork therefore by law we have to consider [him/her] a fullcode [sic]."	N 306		

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N 306	Continued From page 12 04/02/2024 at 7:45 AM written by Caregiver P - "Writer spoke with [Licensee A] to confirm and residents POA [spouse] is infact [sic] active as of March 11, 2024." 04/09/2024 at 9:15 PM written by Caregiver Q - "[Resident 2] came back from the hospital today and [his/her] [spouse] met [him/her] here. they [sic] both had about an hour long [sic] meeting with two nurses. resident [sic] is now on hospice." The Emergency Care Do Not Resuscitate Order was dated 04/06/2024 and indicated Resident 2's DNR status. The POAHC document, signed 10/31/2022, did not indicate Resident 2's DNR status. The individual service plan (ISP), dated 02/26/2024, did not indicate Resident 2's DNR status. The ISP updated on 04/10/2024 with Resident 2's admission indicated Resident 2 was on comfort measures but did not indicate DNR status. On 05/29/2024 at 11:11 AM, Surveyor interviewed Caregiver M about the concern with having DNR paperwork for EMTs when they arrived. Caregiver M stated s/he had never been in that situation yet but would print out the resident's medications and check in the electronic record for code status and if they were on hospice. Caregiver M stated s/he had not had much training on that yet. Caregiver M had a hire date of 02/02/2024. On 07/09/2024 at 2:30 PM, Surveyor discussed the above concern with Licensee A, Administrator B, and Registered Nurse (RN) J. Administrator B confirmed s/he would be the one to update any	N 306		

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(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 306	Continued From page 13 changes in Resident 2's code status, POAHC activation status, and ISP in his/her record. RN J stated all staff were trained to look at the resident's face sheet to know what their code status was. Administrator B stated they did train staff where to look for the code status and it was staff's responsibility to familiarize themselves with each resident's code status. The provider did not ensure Resident 2's advance directive/DNR order or bracelet were available so emergency personnel could be aware of their wishes in imminent death situations. On 04/02/2024, Caregiver P was unable to produce paperwork to provide EMTs with Resident 2's code status.	N 306		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 2 received all his/her medications as prescribed. Resident 2 did not receive his/her scheduled insulin, roflumilast, and levothyroxin as ordered. This is a repeat deficiency. See Statement of Deficiency (SOD) LHMG11, dated 10/05/2021, SOD ZY4711, dated 12/07/2021, SOD ZY4712,	N 352		

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N 352	Continued From page 14 dated 06/22/2022, SOD J0MI11, dated 09/09/2022, SOD ZY4713, dated 02/09/2023, and SOD ZY4714, dated 07/28/2023. Findings include: On 04/03/2024, the Department received a complaint alleging residents were not receiving their medications as prescribed. On 05/292024, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 01/04/2024. Resident 2 had multiple diagnoses, including: type 2 diabetes mellitus, chronic kidney disease, diabetic neuropathy, obstructive sleep apnea, morbid obesity, and paroxysmal atrial fibrillation. Resident 2's prescribed medication orders included, in part: - Roflumilast 500 microgram (mcg) tablet given once daily - Aspart insulin injection given 4 Units subcutaneously every morning - Aspart insulin injection given 6 Units subcutaneously at lunch and at dinner - Glargine insulin 100 Units/milliliters (ml) injection given 20 Units subcutaneously every evening before a meal - Levothyroxin 25 mcg table given once daily. Resident 2's January 2024 medication administration record (MAR) indicated staff charted Resident 2 received his/her prescribed roflumilast twice per day at 7:00 AM and 8:00 PM, 21 times from 01/05/2024 through 01/25/2024, instead of the prescribed once daily. Staff charting indicated Resident 2 did not receive his/her prescribed aspart insulin 4 Units until the	N 352		

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morning of 01/10/2024. Staff charting indicated Resident 2 received prescribed aspart insulin 6 Units 6:00 PM dose on 01/04/2024 and 01/05/2024. Resident 2 then did not receive his/her prescribed aspart insulin 6 Units until 12:00 PM on 01/09/2024. Staff charting indicated Resident received his/her prescribed glargine insulin 20 Units on 01/06/2024 and 01/07/2024 at 8:00 AM. Resident 2 then did not receive his/her prescribed glargine insulin 20 Units until 9:00 PM 01/11/2024. Staff charting indicated Resident 2 did not receive his/her prescribed levothyroxin 25 mcg tablet until 01/09/2024.

Surveyor reviewed the staff progress notes and found the following:

01/05/2024 at 4:45 PM written by Administrator B - "1630H [sic] received a call from [nurse] about [Resident 2's] clarification about meds (medications). [Resident 2's] insulin glargine/toujeo at 20 units at bedtime. [Resident 2's] Levemir was discontinued and replaced with glargine. [Resident 2's] insulin aspart to be given 4 units on breakfast and 6 units lunch and dinner ...[Nurse] stated that [s/he] will send the order to health direct and facility. 1700H [sic] writer called health direct ...Writer asked if [s/he] received the order and [s/he] stated that [s/he] got the fax order but cannot dispense because there is no electronic sign from ER (emergency room) discharge summary and the conversation from [nurse]. Writer talked to [Resident 2] and [s/he] stated [his/her] [spouse] will come this morning and [s/he] will pick up the medications in [pharmacy]."

01/06/2024 at 1:30 PM, written by Caregiver O - "[Resident 2] seems to be concerned about meds and thought needed to pick up from pharmacy

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N 352	Continued From page 16 which is closed today." On 05/29/2024 at 1:53 PM, Surveyor interviewed Caregiver I. Caregiver I stated they had been having issues with getting new prescriptions from the physician for Resident 2. Since s/he had been on hospice, there had been no issues with getting medications. On 07/09/2024 at 2:30 PM, Surveyor interviewed Licensee A, Administrator B, and Registered Nurse (RN) J. Administrator B stated Resident 2's medications needed to be updated at admission and they were waiting for the physician to refill them. Administrator B stated Resident 2 was not sent with any medications from his/her previous facility when s/he was admitted.	N 352		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received prompt and adequate treatment on 04/09/2024, when s/he experienced a change in condition and 911 was not promptly called. This is a repeat deficiency. See Statement of Deficiency (SOD) ZY4713, dated 02/09/2023. Findings include:	N 353		

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N 353	Continued From page 17 On 04/10/2024 and 04/12/2024, the Department received 2 complaints related to the provider's response to changes in a resident's condition. The provider is licensed to care for 19 residents in the client groups physically disabled, irreversible dementia/Alzheimer's disease, terminally ill, and advanced aged. On 05/29/2024, Surveyor conducted a survey in conjunction with Office of Caregiver Quality (OCQ) Investigator R and reviewed Resident 1's record. Resident 1 was admitted to the facility on 06/08/2023 and expired on 04/10/2024. Resident 1 had a guardian and diagnoses that included malignant neoplasm of prostate, type 2 diabetes mellitus, major depressive disorder, anxiety disorder, chronic obstructive pulmonary disease, and chronic kidney disease with dialysis 3 times per week. An incident report, dated 04/09/2024 and written by Assistant Administrator (AA) C, read, in part, "This morning when arriving to [sic] the facility staff notified writer that [Resident 1] passed away this morning. [S/he] was found in [his/her] room around 2:16 AM struggling to breathe. Staff attempted to arouse [him/her] by shaking [him/her] and talking loud and the only response was [him/her] struggling to swallow. [Caregiver D] attempted to call [Administrator B, AA C, Licensee A, home health, and Guardian E]. [Caregiver D] was advised by [Guardian E] and [Licensee A] to call 911. [Caregiver D] first attempted to call at 2:35 [sic] and the call got dropped. [S/he] attempted again and was finally able to get through at 2:38 AM. The 911 operator	N 353		

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advised them to do CPR (cardiopulmonary resuscitation) on [Resident 1]. Staff got [Resident 1] on the ground and did CPR on [him/her]. [Caregiver F] did CPR on [Resident 1] for 18 minutes until the EMT's (emergency medical technicians) arrived. [Resident 1] was pronounced dead at 4:28 AM ...[Guardian E] is aware and upset with how things transpired, [s/he] stayed on the phone while all this took place ..."

The staff progress notes indicated the following:

04/09/2024 at 2:30 AM, written by Licensee A - "at [sic] 225am [sic], writer received a call from [Caregiver D] regarding [Resident 1] that [s/he] is having difficulty breathing. instructed [sic] [Caregiver D] to call 911 now and then call the guardian after saying that [Resident 1] is not with home health. writer [sic] [Administrator B] and was unable to reach but called back at around 238am [sic], and [s/he] said [s/he] is on the phone with [Caregiver D]."

04/09/2024 at 2:15 PM, written by Administrator B - "As per conversation with the staff on duty last night. The staff was doing rounds around 2:16AM, [s/he] noted [Resident 1] is having difficulty breathing so [s/he] called Medpasser [sic] to checked [sic] on [him/her]. Medpasser [sic] tried to arouse [him/her] by shaking and talking loud to the resident. Staff tried calling [Administrator B], [AA C] but unable to reach so [s/he] called [Licensee A] 0225H [sic]. As per staff, [s/he] called homehealth [sic] and [MCO]. While on the phone with [Licensee A], they were informed to call [Guardian E] and 911. Staff called [Guardian E] around 0230H and informed about resident's current status. As per staff, [s/he] called 911 at 0235 [sic] and line got off, 0236-

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0238H [sic] the line got off til [sic] 4 calls. 0239H [sic] Staff received a call from 911 and they informed what happened and were instructed what to do and perform CPR while 911 is on the line. Both staff were doing CPR as instructed by the 911 agent ..."

04/09/2024 at 4:15 PM, written by Caregiver F - "Writer was making rounds at 208am [sic] noticed resident was not looking well [s/he] was very pale [sic] writer went to speak with co-staff with my concerns [sic] co-staff went with writer to resident's room [sic] resident was not responding. Writer then returned with co-staff to desk and and [sic] co-staff spoke with [Licensee A] indicated to call the gradian [sic]. co-staff [sic] spoke with gradian [sic]. And then [s/he] called 911 [sic] 911 op [sic] walked writer thru cpr [sic] writer applied cpr [sic] for sometime [sic] till [sic] emt (emergency medical technician) arrived then took over."

A MCO case report, dated 04/01/2024 to 04/30/2024, read, in part, "-email from [AA C]-[Provider] reporting that [his/her] passing was 'somewhat unexpected.' [AA C] went on to report that [Resident 1] had major decline when returning back to the facility after being hospitalized. [S/he] refused to go to dialysis Saturday. [AA C] reported that their staff stated [s/he] was up and about yesterday afternoon. [S/he] was conversing with staff 'normally.' When staff completed their rounds at 2 AM [sic] today they noticed that [s/he] was 'struggling to breathe and had a rattle.' [AA C] relayed that 'According to the staff on last night they attempted to reach out to Myself [sic], [Administrator B], HH (home health), [Guardian E], and [Licensee A]. After talking to [Licensee A] and [Guardian E] they advised [him/her] to call 911. CPR was performed

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on [him/her] until paramedics arrived and took over ...[Guardian E] reported that [s/he] received a call at 2:30AM [sic] this morning from [Caregiver D] who stated to [him/her] 'I think [Resident 1] might have just taken [his/her] last breath' [sic] [Guardian E] reported that [s/he] asked if [Caregiver D] had called 911. [Caregiver D] reported that [s/he] called [home health provider], who told [him/her] to call [MCO] and then [s/he] called [Guardian E]. [Guardian E] asked what time this all happened, and [Caregiver D] reported 'I think it happened at 2:08.' [Caregiver D] then went on to state that [Resident 1] is on Hospice and is a DNR (do not resuscitate) ...[Guardian E] reported that [s/he] relayed to [Caregiver D] that [Resident 1] is not a DNR and [s/he] is not on Hospice. [Caregiver D] stated that [Resident 1] is on [home health and hospice]. [Guardian E] relayed that [Resident 1] had [home health] prior to [his/her] hospitalization and discharge but they are no longer in place and [s/he] never had Hospice thru [sic] them ... [Guardian E] then reported that another staff [Caregiver F] arrived and [Caregiver D] asked if [s/he] knew how to give CPR. [Caregiver F] stated [s/he] did and [s/he] began CPR until the paramedics arrived at 2:57 AM."

On 06/26/2024 at 12:59 PM, Surveyor received and reviewed the home health visit notes. A note indicated Resident 1 was discharged from home health services on 04/01/2024 due to a hospitalization.

An after visit summary (AVS), dated 03/29/2024 through 04/04/2024, indicated home health services were ordered for nursing, physical therapy, and occupational therapy. The AVS did not indicate Resident 1 was admitted to hospice or had a DNR code status.

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N 353	Continued From page 21 The ambulance report, dated 04/09/2024, indicated a call was received by the provider at 2:43 AM for emergency medical services. The report indicated initial CPR was started by assisted living staff at 2:45 AM. Lifesaving efforts were terminated at 3:31 AM. The facility phone's call log indicated the following on 04/09/2024: -Administrator B had an initial phone call from staff at 2:18 AM. Administrator B declined a phone call at 2:41 AM. Administrator B had at least 2 additional phone calls from staff. -AA C had an initial phone call from staff at 2:19 AM and another call at 2:30 AM. -Licensee A had an initial phone call from staff at 2:25 AM. -The emergency services were called initially by staff at 2:35 AM. On 05/29/2024 at 11:50 AM, Surveyor asked Assistant Administrator (AA) C if Resident 1 was a full code or DNR. AA C stated that initially, s/he thought Resident 1 was DNR but stated s/he was unsure if it was ever changed to DNR as there had been talk about changing code status to DNR and enrolling Resident 1 in hospice. AA C stated the provider did not have any other process in place for staff to easily know what a resident's code status was other than electronic record and care plan. AA C confirmed Resident 1 declined dialysis the Saturday prior to Resident 1's death. AA C stated Caregiver D found Resident 1 struggling to breath at 2:18 AM and did not call 911 until 2:39 AM. AA C stated Caregiver D called everyone else before calling 911. Surveyor asked AA C who was on call that shift. AA C stated s/he could not remember if Administrator B or s/he	N 353		

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was on call that shift but had his/her phone on vibrate due to not wanting his/her child to be woken. AA C stated s/he did not hear the phone when Caregiver D called twice that morning. AA C stated s/he investigated the incident and Caregiver D resigned 2 weeks after. AA C stated Administrator B was aware of Resident 1's condition and was present at the facility on 04/08/2024. AA C stated Caregiver N had concerns on 04/08/2024, during his/her evening shift, but never notified management or charted in the staff progress notes. AA C stated staff were re-educated to now call 911, whether a resident was on hospice or not if they had a change in condition.

On 05/29/2024 at 12:51 PM, Surveyor interviewed Administrator B. Administrator B stated Licensee A was backup for staff to call if AA C or s/he could not be reached. Licensee A was the fifth call Caregiver D made and directed Caregiver D to call Guardian E and 911. Caregiver D ended up calling Guardian E before 911. Administrator B stated Caregiver D thought Resident 1 was a DNR and did not check the record. Administrator B stated Caregiver D was not able to think correctly during the incident and expressed that was not acceptable. Administrator B stated staff were responsible for familiarizing themselves with each resident's code status. Administrator B stated that after Resident 1's last hospitalization, s/he had been declining and there were potential complications with him/her declining Saturday dialysis. Administrator B stated that on 04/08/2024, Resident 1 was doing well. Administrator B stated Caregiver N had never informed him/her of Resident 1's change in condition on the evening of 04/08/2024. Administrator B confirmed staff were not trained or expected to do CPR at the facility unless EMS

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instructed them to do so via phone. Administrator B stated they created a new protocol after the incident due to staff being hesitant who to call first.

On 05/29/2024 at 3:00 PM, Surveyor interviewed Licensee A. Licensee A stated Guardian E was on the phone with staff the entire time of the incident, which caused them to have to run back and forth with the phones. Licensee A stated staff were also having trouble with the phone service and phone calls dropping. Licensee A stated these were some of the issues contributing to the delay in 911 being notified.

Surveyor reviewed an interview between OCQ Investigator R and Caregiver D, dated 07/08/2024. The interview stated in part, "I asked [Caregiver D] to explain what occurred with [Resident 1] during [his/her] shift on April 9, 2024. [Caregiver D] stated that [Caregiver F] had checked on [Resident 1] around 2:00am [sic] and believed that [Resident 1] 'had taken [his/her] last breath.' [Caregiver D] stated during shift change [Caregiver N] had stated that [Resident 1] was a DNR status and [s/he] would likely pass during the night. [Caregiver D] stated after [Caregiver F] advised [him/her] about [Resident 1's] change in condition [s/he] attempted to call [Administrator B and AA C] but was unable to reach them. [Caregiver D] stated [s/he] also attempted to call [MCO] and made contact with [Licensee A] 'did not tell me to call 911.' [Caregiver D] stated that [Licensee A] told [him/her] to call [Guardian E] 'but [s/he] is saying [s/he] told me to call 911' because [s/he] wants to expand [the facility] ... [Caregiver D] stated when [s/he] spoke to [Guardian E] [s/he] advised [Caregiver D] to call 911 as [Resident 1] was a full code. [Caregiver D] stated [s/he] called 911 ...I asked [Caregiver D] if

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N 353	Continued From page 24 [s/he] had checked [Resident 1's] care plan regarding [his/her] DNR status. [Caregiver D] stated [s/he] did not check [his/her] care plan immediately and that [Caregiver N] told [him/her] at shift change 'When [Resident 1] passes call home health and hospice.' I asked [Caregiver D] if [s/he] confirmed this information by reviewing [Resident 1's] care plan. [Caregiver D] stated [s/he] did not know what DNR meant because 'they don't do this in the Philippines,' that everyone receives CPR...[Caregiver D] repeatedly stated [Licensee A] did not tell [him/her] to call 911." Surveyor reviewed an interview between OCQ Investigator R and Caregiver F, dated 07/11/2024. The interview stated, in part, "I asked [Caregiver F] to explain what happened with [Resident 1] on April 9, 2024. [Caregiver F] stated [Caregiver D] approached [him/her] stating [Resident 1] 'wasn't doing well.' When [Caregiver F] asked [Caregiver D] for more information [s/he] stated 'There's nothing we can do [s/he's] DNR.' [Caregiver F] stated [s/he] asked [Caregiver D] if [s/he] was sure [s/he] had a DNR status at which time [s/he] left [Resident 1's] room to check [his/her] care plan on the computer. [Caregiver F] stated after several minutes [Caregiver D] came running into [Resident 1's] room stating [s/he] was 'full code.' [Caregiver F stated that [Caregiver D] made several phone calls attempting to reach management however still had not called 911. [Caregiver F] stated [s/her] started performing CPR on [Resident 1] until EMS arrived ...I asked [Caregiver F] about the numerous phone calls [Caregiver D] stated [s/he] made attempting to contact administration. [Caregiver F] confirmed [Caregiver D] did make several calls however the calls were not answered, which [s/he] stated was not unusual. [Caregiver F] stated [Caregiver D]	N 353		

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should have called 911 immediately as well as checking [his/her] care plan for [his/her] DNR status instead of assuming [s/he] was not a DNR. [Caregiver F] stated at the time of this incident on April 9, 2024, [Caregiver D] was the 'lead' caregiver ...'[Caregiver D was basically my boss because [s/he] was a med passer' ...I asked [Caregiver F] if any information regarding [Resident 1] was passed on by the previous shift. [Caregiver F] stated that [Caregiver N] told [him/her] and [Caregiver D] 'that [Resident 1] would be passing that night'. [Caregiver F] stated that [Caregiver N] also stated that [Resident 1] had a DNR status."

On 07/09/2024 at 2:30 PM, Surveyor interviewed Licensee A, Administrator B, and Registered Nurse (RN) J about the circumstances surrounding Resident 1's death. RN J stated Caregiver D was panicked and called management before 911. RN J stated they could not control a staff's emotional reaction to an incident. Administrator B stated Caregiver D thought Resident 1 was on hospice and a DNR. Administrator B confirmed Resident 1 had been discharged from home health a week prior and they had been trying to find a new company. Surveyor asked who oversaw updating any changes in services to a resident's record and notifying staff. Administrator B stated it was his/her responsibility. Administrator B stated if staff would have informed him/her about Resident 1's change in condition s/he would have been able to educate staff what to do in the situation. RN J stated all staff had been trained where to look to find a resident's code status. RN J stated the facility's phone system had poor connection and that contributed to the delay in Caregiver D getting through to 911.

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N 353	Continued From page 26 The provider did not ensure Resident 1 received prompt and adequate treatment on 04/09/2024, when s/he experienced a change in condition and died. Caregiver D observed Resident 1 take his/her last breath at approximately 2:08 AM and emergency medical services (EMS) were not reached until 2:43 AM due to Caregiver D assuming Resident 1 was on hospice and had a DNR code status. Caregiver D also made multiple phone calls reaching out to management, the MCO, and Guardian E prior to calling 911.	N 353		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 had a comprehensive individualized service plan (ISP) that identified Resident 1's needs and desired outcomes related to his/her wound care and	N 386		

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advanced directives for cardiopulmonary resuscitation (CPR).

Resident 1 sustained a scrape to his/her right toes on 01/28/2024 that was not consistently monitored or assessed by facility staff. The wounds developed into cellulitis and on 03/02/2024, the toes were amputated.

Resident 1 was found unresponsive on 04/09/2024 and staff believed Resident 1 was a DNR (do not resuscitate) and on hospice. Staff made multiple phone calls prior to calling 911.

This is a repeat deficiency. See Statement of Deficiency (SOD) ZY4714, dated 07/28/2024 and SOD ZY4715, dated 02/23/2024.

Findings include:

On 03/19/2024 and 04/03/2024, the Department received complaints alleging resident care needs were not being met by the provider and resident ISPs did not clearly indicate DNR status.

The facility is licensed to serve up to 19 residents from the following client groups: irreversible dementia/Alzheimer's, terminally ill, physically disabled and/or advanced age.

On 05/29/2024, Surveyor conducted a survey in conjunction with Office of Caregiver Quality (OCQ) Investigator R and requested Resident 1's records.

The face sheet indicated Resident 1 had an admission date of 06/08/2023 and diagnoses that included: malignant neoplasm of prostate, type 2 diabetes mellitus, chronic kidney disease with dialysis support, major depressive disorder,

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anxiety disorder, and chronic obstructive pulmonary disease. Resident 1 had a guardian and the face sheet indicated in green under his/her name that Resident 1 was a full code. The face sheet also indicated Resident 1 received home health services.

The power of attorney for health care (POAHC) document did not indicate Resident 1's preference for CPR or code status. The document was signed by two witnesses on 05/03/2016.

The individual service plan (ISP), dated 04/04/2024, did not indicate Resident 1's code status. The ISP did not indicate Resident 1's needed wound care or if s/he received home health services for wound care.

On 06/26/2024 at 12:59 PM, Surveyor received and reviewed the home health visit notes.

A communication note, dated 02/26/2024, read, "Facility called stating they would like an update on patient's wound to foot. Facility was notified that we were unaware of any wound, as it had not been reported to us and we are in there for monthly catheter changes. SN (skilled nurse) is due to be out today, will look at area to determine what kind of wound and treatment will be needed and update MD (physician) for orders."

A note indicated Resident 1 was discharged from home health services on 04/01/2024 due to a hospitalization.

An after visit summary (AVS), dated 03/29/2024 through 04/04/2024, indicated home health services were ordered for nursing, physical therapy, and occupational therapy. The AVS did

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not indicate Resident 1 was admitted to hospice or his/her code status had changed to DNR while hospitalized.

On 05/29/2024 at 11:11 AM, Surveyor asked Caregiver M where s/he would look to find a resident's code status. Caregiver M stated s/he would look on the electronic record or in the resident's ISP. Caregiver M indicated staff always have access to resident records.

On 05/29/2024 at 11:50 AM, Surveyor interviewed Assistant Administrator (AA) C. AA C stated the provider did not have any other process in place for staff to easily know what a resident's code status was other than the electronic record and ISP.

On 05/29/2024 at 12:51 PM, Surveyor interviewed Administrator B. Administrator B stated staff would be able to check the electronic record immediately to know what a resident's code status was. Administrator B stated they did train staff where to look for the code status and it was staff's responsibility to familiarize themselves with each resident's code status.

On 05/29/2024 at 1:53 PM, Surveyor asked Caregiver I if Resident 1 was a full code or DNR. Caregiver I stated Resident 1 was never a DNR and staff had access to a resident's code status in the electronic record or ISP. Caregiver I stated home health services started to follow Resident 1 for wound care and s/he, along with another staff, were trained on wound care by home health. Caregiver I stated they then trained other staff how to perform wound care for Resident 1.

On 05/29/2024 at 2:40 PM, Surveyor asked Caregiver N if Resident 1 was a full code or DNR.

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N 386	Continued From page 30 Caregiver N stated Resident 1 was a DNR. Surveyor showed Caregiver N Resident 1's face sheet where it indicated under his/her name in green a full code status. Caregiver N stated Resident 1's code status changed to DNR, and s/he was discharged from home health services after his/her last hospitalization. Caregiver N stated this information was not communicated to staff. Caregiver N confirmed home health was managing Resident 1's wounds and staff were monitoring the wound and changing the dressing as needed. Surveyor reviewed an interview between OCQ Investigator R and Caregiver D, dated 07/08/2024. Caregiver D worked the night of Resident 1's death. The interview indicated OCQ Investigator R asked Caregiver D to verify Resident 1's code status on his/her ISP. The interview stated, "s/he did not know what DNR meant because 'they don't do this in the Philippines,' that everyone receives CPR." The interview indicated OCQ Investigator R showed Caregiver D Resident 1's face sheet and asked him/her to state what it said below Resident 1's name. The interview indicated Caregiver D did not verbalize the "FULL CODE" status indicated below Resident 1's name. Surveyor reviewed an interview between OCQ Investigator R and Caregiver F, dated 07/11/2024. Caregiver F worked the night of Resident 1's death. OCQ Investigator R asked Caregiver F how s/he would know a resident's code status. The interview indicated Caregiver F stated the code status would be in the resident's electronic record. The interview indicated Caregiver F was unsure where the ISP would indicate a resident's code status.	N 386		

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N 386	Continued From page 31 On 07/09/2024 at 2:30 PM, Surveyor discussed the above concern with Licensee A, Administrator B, and Registered Nurse (RN) J via phone during an exit conference. Administrator B confirmed home health services were discharged a week prior to Resident 1's death after his/her last hospitalization and they were trying to find a new home health service provider. Administrator B confirmed s/he would be the one to update Resident 1's code status and support services in his/her record. RN J stated all staff were trained to look at the resident's face sheet to know what their code status was and if they received support services. The provider did not ensure Resident 1 had a comprehensive ISP that identified Resident 1's needs and desired outcomes related to his/her wound care, support services, and advanced directives for CPR if his/her heart or breathing stopped, prior to his/her death on 04/09/2024. Cross Reference N0353 DHS 83.32(3)(i) Rights Of Residents: Adequate Treatment N0431 DHS 83.38(1)(g) Health Monitoring	N 386		
N 431	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services	N 431		

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N 431	Continued From page 32 unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received appropriate health monitoring to meet their needs. Resident 1's skin was vulnerable and prone to breakdown. Resident 1 sustained a toe wound not consistently monitored or assessed by facility staff. The toe was eventually amputated. This is a repeat deficiency. See Statement of Deficiency (SOD) ZY4712, dated 06/22/2022. Findings include:	N 431		

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N 431	Continued From page 33 On 03/19/2024, the Department received a complaint alleging resident care needs were not being met by the provider. The facility is licensed to serve up to 19 residents from the following client groups: irreversible dementia/Alzheimer's, terminally ill, physically disabled and/or advanced age. On 05/29/2024, Surveyor reviewed Resident 1's records. Resident 1 had an admission date of 06/08/2023 and diagnoses that included malignant neoplasm of prostate, type 2 diabetes mellitus, chronic kidney disease with dialysis support, major depressive disorder, anxiety disorder, and chronic obstructive pulmonary disease. Surveyor reviewed staff observation notes, dated 01/01/2024 through 05/29/2024, which indicated the following: 01/28/2024 9:45 AM, written by Caregiver G - Resident 1 had an unwitnessed fall. " ...Right foot 2nd toe had a small scrape by last toe knuckle before toenail starts, med [sic] passer put a bandaid [sic] on it." 01/29/2024 12:45 PM, written by Administrator B - " ...writer was notified by staff that res (resident) had a fall incident yesterday and had a small scrape/ abrasion on the 2nd toe. Writer check [sic] on the resident's wound. Res denies pain and stated 'It's nothing.' Cleansed the wound with water and soap. Res feels comfortable at this. For monitoring and prevent further injury." 01/30/2024 1:30 PM, written by Administrator B - "	N 431		

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N 431	Continued From page 34 ...Checked on res right toe that had a small scrape. Dressing dry and intact." 02/01/2024 2:45 PM written by Caregiver G - " ...Resident usually likes taking scheduled shower after breakfast, and on right 2nd and 3rd toes where the two bigger scabs are, the 2nd toe scab is looking deeper and the entire toe looks pretty red, and the 3rd toe is looking red and not the entire toe yet...Med (Medication) passer notified. Cream on the toe scabs..." 02/01/2024 3:00 PM, written by Licensee A - "writer informed of scabs and deeper wound on 2nd toe of rt (right) foot. home health informed, guardian informed." 02/08/2024 9:15 AM, written by Assistant Administrator (AA) C - "This writer just called [physician] office to let them know about [his/her] toe from when [s/he] fell a [sic] on 1/28 and [his/her] cut it open. It is now looking pretty nasty and infected. The nurse said [s/he] was going to send a message back to the provider about getting a topical and oral antibiotic for [him/her]. Waiting for a response back." 02/08/2024 6:45 PM, written by Caregiver H - " ...resident was sent to ER (emergency room) due to RT (right) toes concern and further assessment evaluation and treatment." 02/08/2024 8:45 PM, written by Licensee A - " ...diagnosed with cellulitis with new orders of antibiotics." 02/23/2024 8:00 AM written by Licensee A - "Writer was called by caregiver & medpasser [sic] to look at the right foot toes of [Resident 1]. There was [sic] open wounds on top of 2nd toe and 3rd	N 431		

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toe. Instructed for medpasser [sic] to call home health for instructions."

02/26/2024 2:00 PM, written by Caregiver I - "Writer called residents home health ...writer stated in the voicemail that the ulcer on resident right foot, middle toes looks to be getting infected. It has a pussy film on the top and is slightly bleeding. Waiting on a call back."

02/26/2024 6:45 PM, written by Licensee A - "[Resident 1] was sent to ER due to [his/her] wound on [his/her] Rt 2nd toe, after home health nurse saw [Resident 1's] foot and recommended [him/her] to be sent to the ER "

02/29/2024 3:15 PM, written by Registered Nurse (RN) J - " ...Res is doing well right now after the amputation of [his/her] 2 right toes and [s/he] was palced [sic] in antibiotics IV ..."

Surveyor reviewed Resident 1's medical notes.

The medical note, dated 02/08/2024, read, in part, " ...Reportedly patient had bumped [his/her] toes on 01/28 in [his/her] [sic] since had some redness. There is a scab and some redness now involving the 3rd and 4th toes. There was some greenish pus coming from it ...Cellulitis gout fracture less likely necrotizing skin or soft tissue infection, osteomyelitis, lymphangitis bacteremia others considered."

The medical note, dated 03/02/2024, indicated Resident 1 was hospitalized and received a 2nd and 3rd digit amputation with secondary osteomyelitis ulceration and cellulitis. The note read, in part, " ...There is redness around area and able to flush out some of what appears to be eschar (grey/brown) slough appearance. Bone is

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visible with muscle and skin pulled away from area. Tip of toe is now freely moving from joint, though connected with skin and no skin break down noted on the bottom (dorsal portion) of 2nd toes ..."

On 06/26/2024 at 12:59 PM, Surveyor received and reviewed the home health visit notes.

A communication note, dated 02/26/2024, read, "Facility called stating they would like an update on patient's wound to foot. Facility was notified that we were unaware of any wound, as it had not been reported to us and we are in there for monthly catheter changes. SN (skilled nurse) is due to be out today, will look at area to determine what kind of wound and treatment will be needed and update MD (physician) for orders."

A skilled nurse visit note, dated 02/26/2024, read, in part, " ...Staff called to report area bleeding on right toe. Upon examination of the area mixed etiology pressure and dm2 noted to be 1.4x1.5 cm unable to see wound bed due to slough and possible exposed bone area firm yellowwhite [sic] in color 0.5 x1cm. Redness surrounding and to tip of toe. 3rd toe has 0.4 x0.5x0.3 cm wound with surrounding redness. Patient left 2nd toe has 04 x0.5 cm scab without redness. [Physician] updated sending to er (emergency room) for evaluating examination."

A skilled nurse visit note, dated 03/19/2024, read, in part, "Spoke with [Managed Care Organization] about facility not communicating skin issue. Staff [AA C] education given infection to call interim for any new skin concerns, if dressings come off or changes with patient as [s/he] has multiple comorbidities and visits are only 2 xweek [sic] but as needed appointment can occur if issues arise

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017970	A. BUILDING: _____ B. WING _____	C 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS OF STRUM	208 ELM STREET PO BOX 182 STRUM, WI 54770

(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 431	Continued From page 37	N 431		

to prevent rapid decline or adverse effects."

On 06/26/2024 at 12:34 PM, Surveyor interviewed Home Health Nurse (HHN) L. HHN L had a visit with Resident 1 earlier in the day for urinary catheter care, which was all home health was overseeing for Resident 1. HHN L stated the provider did not initially communicate Resident 1's wounds. HHN L stated s/he returned later in the day to the facility and felt the wounds were significant and recommended Resident 1 be sent for medical evaluation. HHN L stated s/he did not know how the wounds became so intense that quickly. HHN L stated s/he did not think Resident 1 was in the appropriate setting for the wound care s/he required and the staff's skill level to care for him/her.

On 07/09/2024 at 2:30 PM, Surveyor interviewed Licensee A, Administrator B, and RN J. Administrator B confirmed s/he checked on Resident 1's right toes the next day after s/he scraped them on 01/28/2024. Administrator B stated s/he notified home health about Resident 1's toe wounds on 02/01/2024. Administrator B explained wound care was coordinated with home health and Resident 1 had a behavior of picking and scratching at his/her skin which affected the healing of his/her wounds. Administrator B stated staff were not able to monitor Resident 1 24/7 to prevent the behavior. Surveyor asked when home health had been notified and took over wound care. RN J stated staff were applying Bactrim to Resident 1's wounds prior to home health taking over wound care. RN J stated s/he assumed home health was supposed to do a full head to toe assessment and check on Resident 1's skin integrity. RN J stated they had been relying on home health to look at Resident 1's skin and felt

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(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 431	Continued From page 38 there was miscommunication. RN J stated s/he was unsure when home health was actually notified and when they took over wound care for Resident 1. The provider did not ensure Resident 1's health was monitored when Resident 1's skin was vulnerable and prone to skin breakdown. Resident 1 sustained a scrape to his/her right toes on 01/28/2024 that were not consistently monitored or assessed by facility staff. The wounds developed into cellulitis and eventually the toes were amputated. The provider assumed the home health agency was monitoring Resident 1's skin. Home health was not notified until 02/26/2024 of Resident1's toe wounds when bone already showed in the wound, and cellulitis had developed.	N 431		