STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014395	A. BUILDING: _____ B. WING _____	R-C 05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK PLACE WAUWATOSA	1621 RIVERS BEND WAUWATOSA, WI 53226

(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 05/02/2024 with information gathered through 05/08/2024, Surveyor conducted a standard survey, a verification visit and three complaint investigations at Oak Park Place Wauwatosa. Fourteen deficiencies identified. Eight of 14 were repeat deficiencies. Two of 3 complaints substantiated. One complaint unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 46	{N 000}		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an investigation was conducted for 1 of 1 incident, when Resident 21 was observed with injuries of an unknown source. Findings include: On 05/03/2024 at approximately 10:35 AM, Surveyor reviewed Resident 21's record. Resident 21 admitted to the provider's facility on	N 161		

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

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N 161	Continued From page 1	N 161		

11/27/2023. Resident 1 was his/her own person and made his/her own decisions. Resident 21's record included a progress note, dated 12/20/2023, at 3:36 PM, that stated, "Family concerned about 1-hour checks not being in place and bruise over [Resident 21's] right eye. Family certain something happened 12/19/2023 that was unreported. Spoke with [Caregiver DD] who worked 12/19/2023 morning shift and noticed eye was bruised the morning of 12/19/2023 when AM shift got [him/her] up and reported to [DON EE] attention. Spoke with [Caregiver Z] who worked overnights 12/18/2023-12/19/2023 and [s/he] confirmed there were not falls on overnights. It seems this stems from [his/her] fall on 12/17/2023, or less likely [Resident 21] fell, helped [him/herself] up, and staff were unaware."

Resident 21's record did not document a cause of the bruise, or any follow up documentation regarding the bruise.

On 05/08/2024 at 2:00 PM, Surveyor interviewed DOH AA and Regional Registered Nurse (RN) Q regarding Resident 21's bruise to his/her right eye on 12/19/2023. Regional RN Q stated the bruise was from the previous fall Resident 21 had on 12/17/2023. Surveyor asked Regional RN Q if there was additional documentation regarding Resident 21's status/bruising after the fall on 12/17/2023 to connect it to the right eye bruise that family reported to them on 12/20/2023. Regional RN Q stated, "no," and s/he could not find any documentation stating Resident 21 had bruising by his/her right eye. At approximately 2:15 PM, Surveyor reviewed concern that Resident 21 had sustained an injury of an unknown source and the cause was not investigated. DOH AA and Regional RN Q acknowledged concern and stated moving

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N 161	Continued From page 2 forward they will follow up and work on their documentation.	N 161		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure complete background checks were conducted upon hired for 2 of 4 employees reviewed. Caregiver CC and Caregiver DD did not have a complete background check completed. The complete background check is to include the background information disclosure form (BID), the criminal history search form from the department of justice (DOJ), and the information maintained by the department of safety and professional service regarding a person's credentials (IBIS).	N 219		

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N 219	Continued From page 3 Findings include: On 05/06/2024, Surveyor reviewed employee records and identified the following: -Caregiver CC was hired 03/06/2020 and his/her record did not include a BID form, DOJ, and IBIS letter. -Caregiver DD was hired 03/06/2020 and his/her record did not include a BID form, DOJ, and IBIS letter. On 05/08/2024 at 02:00 PM, Surveyor interviewed DOH AA and Regional RN Q. DOH AA stated s/he could not locate Caregiver CC's and Caregiver DD's background check upon hire. DOH AA stated s/he ran the background checks as of 05/06/2024 to be in compliance and moving forward would ensure all new hires had complete background checks and/or their 4-year background check, if applicable.	N 219		
{N 220}	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes.	{N 220}		

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{N 220}	Continued From page 4	{N 220}		

This Rule is not met as evidenced by:
Based on records review and interview, the provider did not ensure documentation was obtained from a physician, physician assistant, clinical nurse practitioner, or licensed registered nurse indicating 2 of 3 employees reviewed were screened for clinically apparent communicable disease, including tuberculosis (TB), within 90 days before the start of employment.

Caregiver Y and Caregiver Z were not screened for communicable disease including TB within 90 days before the start of employment.

This requirement is being cited for the fourth time. See Statement of Deficiency (SOD) W0M011, dated 10/22/2020, SOD W0M012, dated 07/06/2021, and SOD W0M014, dated 04/27/2023.

Findings include:

On 05/08/2024 at approximately 10:30 AM, Surveyor reviewed Caregiver Y's and Caregiver Z's employee files and identified the following:

Caregiver Y was hired on 02/08/2024. Caregiver Y's file contained documentation indicating Caregiver Y was screened for communicable disease including TB on 04/24/2024, more than 2 months after hire.

Caregiver Z was hired on 02/25/2020. Caregiver Z's file did not contain documentation indicating Caregiver Z was screened for communicable disease, including TB.

On 05/08/2024 at 2:00 PM., Surveyor interviewed

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{N 220}	Continued From page 5 Director of Housing (DOH) AA and Regional Nurse Q. DOH AA stated s/he had been auditing files since s/he was so new and would make sure moving forward all TB skin tests and screenings would be completed upon hire.	{N 220}		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 5 of 5 employees (Caregivers Y, Z, BB, CC and DD) obtained training which included recognizing and responding to resident changes of condition. Findings include: On 05/08/2024, Surveyor reviewed employee records and identified the following: The record for Caregiver Y, hired 02/08/2024, did not contain evidence of orientation topic of recognizing and responding to resident changes	N 230		

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N 230	Continued From page 6 of condition. The record for Caregiver Z, hired 02/25/2024, did not contain evidence of orientation topic of recognizing and responding to resident changes of condition. The record for Caregiver BB, hired 11/15/2023, did not contain evidence of orientation topic of recognizing and responding to resident changes of condition. The record for Caregiver CC, hired 03/06/2020, did not contain evidence of orientation topic of recognizing and responding to resident changes of condition. The record for Caregiver DD, hired 03/06/2020, did not contain evidence of orientation topic of recognizing and responding to resident changes of condition. On 05/08/2024 at 2:00 PM, Surveyor interviewed DOH AA and Regional Nurse Q. DOH AA stated s/he could not locate Caregiver Y's, Caregiver Z's, Caregiver BB's, Caregiver CC's, and Caregiver DD's orientation checklists. DOH AA stated s/he could not confirm orientation training in recognizing and responding to resident changes of condition was completed for Caregiver Y, Caregiver Z, Caregiver BB, Caregiver CC and Caregiver DD. DOH AA stated moving forward s/he would ensure all staff had the training. Cross Reference: N0277 DHS 83.25 Continuing Education	N 230		

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{N 277}	Continued From page 7	{N 277}		
{N 277}	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 employees (Caregivers Z and CC) who required continuing education completed at least 15 hours of continuing education in 2023. This is a repeat violation from Statement of Deficiency (SOD) W0M013 dated 10/25/2022 and SOD W0M014 dated 04/27/2023. Findings include: On 05/08/2024, Surveyor reviewed employee files and identified the following: Caregiver Z was hired 02/25/2020. Caregiver Z's record had no evidence of any continuing education for 2023. Caregiver CC was hired 03/06/2020. Caregiver CC's record had only 4.5 hours of continuing	{N 277}		

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{N 277}	Continued From page 8 education for 2023. On 05/08/2024 at 2:00 PM, Surveyor interviewed DOH AA and Regional Nurse Q. DOH AA stated Caregiver Z was only an as needed employee, but s/he still should have had continuing education hours and s/he was not sure why Caregiver CC did not have enough continuing education hours. DOH AA stated moving forward s/he would ensure staff would have continuing education if applicable. Cross Reference: N0230 DHS 83.19 Orientation	{N 277}		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 residents reviewed	N 302		

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N 302	Continued From page 9 (Resident 20 and Resident 21) were screened for clinically apparent communicable disease, including tuberculosis (TB), by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse within 90 days or 7 days after admission. Findings include: On 05/02/2024, Surveyor reviewed resident records and identified the following: Resident 20 was admitted on 05/23/2023. The documents provided to Surveyor from Resident 20's record did not contain the results of a TB test and a statement showing Resident 20 was free of communicable disease. Resident 21 was admitted on 11/27/2023. The documents provided to Surveyor from Resident 21's record did not contain the results of a TB test and a statement showing Resident 21 was free of communicable disease. On 05/08/2024 at 2:00 PM, Surveyor interviewed DOH AA and Regional Nurse Q. DOH AA and Regional Nurse Q stated they could not find evidence Resident 20 and Resident 21 were screened for TB within 90 days before or 7 days after admission.	N 302		
{N 305}	83.28(6) Resident rights, grievance procedure, rules Resident rights, grievance procedure, and house rules. Before or at the time of admission, the CBRF shall provide and explain resident rights, the house rules of the CBRF as required under s. DHS 83.32 (2), and the grievance procedure,	{N 305}		

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{N 305}	Continued From page 10 including written information regarding the names, addresses and telephone numbers of all resident advocacy groups serving the client groups in the facility, including the long term care ombudsman program and the protection and advocacy services of Disability Rights Wisconsin, Inc. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents reviewed were provided and explained resident rights before or at the time of admission (Resident 21). This is a repeat deficiency and being cited for the third time. See Statement of Deficiency (SOD) W0M013, dated 10/25/2022, and SOD W0M014 dated 04/27/2023. Findings include: On 05/08/2024 at 9:00 AM, Surveyor reviewed Resident 21's record. Resident 21 was admitted to the provider's facility on 11/27/2023. Resident 21's admission paperwork, dated 11/27/2023, did not include documentation that Resident 21 received information about resident rights. On 05/08/2024 at 2:00 PM, Surveyor interviewed DOH AA and Regional RN Q. DOH AA stated Resident 21 should have had resident rights in his/her record like the other residents did. S/he stated s/he was not sure why it was not completed but moving forward would ensure all were filled out upon admission.	{N 305}		
N 352	83.32(3)(h) Rights of Residents: Receive medication	N 352		

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N 352	Continued From page 11 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 all prescribed medications were administered in the dosage and at intervals prescribed by a practitioner for 1 of 1 resident. Resident 22's Diclofenac Sodium External Gel 1% was not available for administration. This is a repeat deficiency for the second time. See Statement of Deficiency (SOD) W0M013, dated 10/25/2022. Findings include: On 05/06/2024 at 12:03 PM, Surveyor reviewed Resident 22's record. Resident 22 was admitted to the facility on 10/16/2023 with diagnoses including fracture of lower leg, hyperlipidemia, neoplasm of unspecific behavior of right kidney, and depression. As of 12/01/2023, Resident 22 had a prescription for Diclofenac Sodium External Gel %1 to apply transdermal areas of pain topically four times (8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM) a day for pain control. Surveyor reviewed Resident 22's medication administration record (MAR) for December 2023. Staff documented Resident 22's Diclofenac Sodium External Gel 1% was not available for administration from 12/18/2023, 8:00 AM. dose to 12/19/2023 at the 8:00 PM. Resident 22 missed	N 352		

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N 352	Continued From page 12 8 consecutive doses of Diclofenac Sodium External Gel 1% because it was not available. On 05/06/2024, at approximately 12:03 PM, Surveyor interviewed DOH AA. DOH AA stated, "On 12/08/2023 and 12/09/2024 documentation not listed in progress notes as indicated. Medication not given at those times. All meds with check mark given." DOH AA confirmed the medication was not given.	N 352		
{N 387}	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident and/or the resident's legal representative, as appropriate, were involved in developing the individual service	{N 387}		

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{N 387}	Continued From page 13 plan (ISP) and signed the plan acknowledging their involvement in, understanding of, and agreement with the plan for 2 of 3 resident records reviewed (Resident 20 and Resident 21). This requirement is being cited for the fourth time. See Statement of Deficiency (SOD) W0M012, dated 07/06/2021, SOD W0M013, dated 10/25/2022, and SOD W0M014 dated 04/27/2023. Findings include: On 05/04/2024 at 04:45 PM, Surveyor reviewed the records of Resident 20 and Resident 21. Resident 20 was admitted on 05/23/2023. Resident 20's ISP, dated 05/23/2023, was not signed or dated by Resident 20's Health Care Power of Attorney. Resident 21 was admitted on 11/27/2023. Resident 21's ISP, dated 11/27/2023, was not signed or dated by Resident 21. On 05/08/2024, at 2:00 PM, Surveyors interviewed DOH AA and Regional Nurse Q. DOH AA stated s/he was not sure why the ISP's were not signed but moving forward would ensure they were signed upon admission and when they were updated.	{N 387}		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of	N 389		

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N 389	Continued From page 14 the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 22) had his/her individual service plan (ISP) updated when there was a change in condition. Resident 22 had changes in his/her health that required hospital admissions from 11/01/2023-11/07/2023 and 12/30/2023-01/16/2024, had a mental status change expressing s/he wanted to die, and required wound care and catheter care by outside agencies. This is a repeat deficiency. See Statement of Deficiency (SOD) W0M013 dated 10/25/2022. Findings include: On 05/02/2024 at approximately 12:00 PM, Surveyor reviewed Resident 22's record, including progress notes, ISP and hospital records. Resident 22 was admitted to the provider's facility on 10/16/2023 with diagnoses including fracture of lower left leg, hyperlipidemia, neoplasm of unspecified behavior of right kidney and depression.	N 389		

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N 389	Continued From page 15 Resident 22's ISP was dated 10/31/2023 and stated the following: -"Resident has indwelling catheter. Offer and encourage fluid intake at meals, with activities and with medication administration times. When providing assistance with care, promptly report to nurse if resident complains of any pain/discomfort, or if there is any redness, odor or drainage on or around the catheter dressing site." -"The resident has risk for potential impairment to skin integrity. Observe skin. Keep clean and dry. Hydrate skin with lotion as needed. Report any skin alterations to nurse. Observe/identify/document potential causative factors for alterations in skin integrity. Elimate/resolve where possible." Resident 22's hospital records from 11/01/2023-11/07/2023 stated the following: -"[Resident 22] presented to ED (emergency department) due to painless hematuria after [his/her] Foley was exchanged yesterday (10/31/23)." -"LLE (lower left extremity) wound d/t skin necrosis after surgical fixation -"per chart review, patient has surgery on 12/11/23 with plastics for skin grafting, staples removed, wound cares ordered, f/u (follow up) as scheduled 11/14/23." Resident 22's progress notes stated the following: -"11/09/2023 at 4:44 PM; Writer changed wound dressing. No signs of infection noted. Tissue appears healthy." -"11/10/2023 at 1:42 PM; Writer changed wound dressing. No signs of infection noted. Tissue appears healthy." -"11/13/2023 at 11:35 AM; Writer provided wound	N 389		

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N 389	Continued From page 16	N 389		

care and changed bandage/dressing, per order specification."
-"11/13/2023 at 5:32 PM; Resident has blood in catheter. Resident c/o (complains of) pain and pressure in pelvis. Writer spoke with Resident's daughter and plan is to send [him/her] to ER (emergency room)."
-"11/14/2023 at 2:31 PM; Writer provided wound care and changed bandage/dressing, per order specification."
-"11/15/2023 at 1:32PM; Writer provided wound care and changed bandage/dressing, per order specification."
-"11/16/2023 at 3:32 PM; Writer provided wound care and changed bandage/dressing, per order specification."
-"11/17/2023 at 9:54 PM; Resident states [his/her] depression is worsening. Resident verbalizes [s/he] just wants to die. Resident is refusing to participate in PT (physical therapy)/OT (occupational therapy) and activities and refuses to get out of [his/her] bed. Writer spoke with Resident's [family member] and suggested possible Hospice admission. [Family member] is agreeable. Writer will have an evaluation on Monday to determine if Resident is a good candidate."

Resident 22's hospital records from 12/30/2023-01/16/2024 stated the following:
-"Follow up with plastic surgery for wound check. Continue daily wound care. Daily dressing change with hydrogel and Mepilex left ankle. No wound care needed to left thigh."
-Wound Care: Keep your surgical areas clean and dry, no dressing is needed to the left thigh, continue wound care to left ankle with dressing changes every 3 days as follows: 1.) cut strip of Aquacel Ag to size of wound and apply to wound, 2.) cover with Mepilex border dressing and 3.)

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N 389	Continued From page 17 Every 3 days remove previous dressing and replace with new. Home Health will be providing home care services to you. The agency will contact you before your first visit. They have confirmed that they will start care on 01/18/2024." On 05/06/2024 at approximately 12:35 PM, Surveyor requested to review follow up documentation regarding Resident 22's hospital admissions when returning to the facility, Resident 22's mental status change expressing s/he wanted to die, documentation of Resident 22's wound care and catheter care by home health. DOH AA and Regional RN Q stated there was no documentation on the follow up by DON EE. On 05/08/2024 at 2:00 PM Surveyor interviewed DOH AA and Regional Nurse Q. DOH AA and Regional Nurse Q stated they did not have an updated ISP from 10/31/2023. DOH AA and Regional Nurse Q stated DON EE should have been updating the ISP when there were changes.	N 389		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not administer nebulizers or an	N 416		

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N 416	Continued From page 18 injectable by a registered nurse or a licensed practical nurse within the scope of the license. Medication administration described under sub. (2)(e) was not delegated to non-licensed employees pursuant to s.N6.03(3) for 2 of 2 unlicensed caregivers who passed medication. Findings include: On 05/06/2024, Surveyor requested to review Caregiver CC's and Caregiver DD's employee records. Caregiver CC and Caregiver DD were hired on 03/06/2020. Neither record contained evidence of nurse delegation. On 05/06/2024 at approximately 12:34PM, DOH AA indicated five residents received insulin. On 05/08/2024 at 2:00 PM, Surveyor interviewed DOH AA and Regional RN Q. DOH AA and Regional RN Q stated Caregiver CC and Caregiver DD passed medications and administered insulin because they worked first shift and second shift. DOH AA stated both Caregiver CC and Caregiver DD were delegated to by a previous nurse that worked there. DOH AA stated the nurse left 03/08/2021, so they both should have been re-delegated to administer insulin by the new nurse.	N 416		
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	N 431		

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N 431	Continued From page 19 monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services 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 monitor and document the health of residents for 1 of 1 resident. Resident 22 had changes in his/her health that required hospital admissions from 11/01/2023-11/07/2023 and 12/30/2023-01/16/2024. The change in Resident 22's health and the hospital admissions were not documented in Resident 22's record.	N 431		

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N 431	Continued From page 20 This is a repeat deficiency. See Statement of Deficiency (SOD) W0M013, dated 10/25/2022. Findings include: On 05/02/2024 at approximately 12:00 PM, Surveyor requested Resident 22's record, including progress notes and hospital records. Resident 22 was admitted to the provider's facility on 10/16/2023 with diagnoses including fracture of lower left leg, hyperlipidemia, neoplasm of unspecified behavior of right kidney and depression. Resident 22's hospital records from 11/01/2023-11/07/2023 stated the following: -"[Resident 22] presented to ED (emergency department) due to painless hematuria after [his/her] Foley was exchanged yesterday (10/31/23)." -"LLE (lower left extremity) wound d/t (due to) skin necrosis after surgical fixation -"per chart review, patient has surgery on 12/11/23 with plastics for skin grafting, staples removed, wound cares ordered, f/u (follow up) as scheduled 11/14/23 Resident 22's progress notes stated the following: -"11/09/2023 at 4:44 PM; Writer changed wound dressing. No signs of infection noted. Tissue appears healthy." -"11/10/2023 at 1:42 PM; Writer changed wound dressing. No signs of infection noted. Tissue appears healthy." -"11/13/2023 at 11:35 AM; Writer provided wound care and changed bandage/dressing, per order specification." -"11/13/2023 at 5:32 PM; Resident has blood in	N 431		

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N 431	Continued From page 21	N 431		

catheter. Resident c/o (complains of) pain and pressure in pelvis. Writer spoke with Resident's daughter and plan is to send [him/her] to ER (emergency room)."
-"11/14/2023 at 2:31 PM; Writer provided wound care and changed bandage/dressing, per order specification."
-"11/15/2023 at 1:32PM; Writer provided wound care and changed bandage/dressing, per order specification."
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-"11/17/2023 at 9:54 PM; Resident states [his/her] depression is worsening. Resident verbalizes [s/he] just wants to die. Resident is refusing to participate in PT (physical therapy)/OT (occupational therapy) and activities and refuses to get out of [his/her] bed. Writer spoke with Resident's [family member] and suggested possible Hospice admission. [Family member] is agreeable. Writer will have an evaluation on Monday to determine if Resident is a good candidate."

Resident 22's hospital records from 12/30/2023-01/16/2024 stated the following:
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-Wound Care: Keep your surgical areas clean and dry, no dressing is needed to the left thigh, continue wound care to left ankle with dressing changes every 3 days as follows: 1.) cut strip of Aquacel Ag to size of wound and apply to wound, 2.) cover with Mepilex border dressing and 3.) Every 3 days remove previous dressing and replace with new. Home Health will be providing home care services to you. The agency will

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N 431	Continued From page 22 contact you before your first visit. They have confirmed that they will start care on 01/18/2024." On 05/06/2024 at approximately 12:35 PM, Surveyor requested to review follow up documentation regarding Resident 22's hospital admissions when returning to the facility and Resident 22's mental status change expressing s/he wanted to die. DOH AA and Regional RN Q stated there was no documentation on the follow up by DON EE. Surveyor requested to review all of the wound care documentation by Home Health since DOH AA and Regional Nurse Q stated the facility did not provide wound care to the residents. DOH AA and Regional Nurse Q did not have any documentation. On 05/08/2024 at 2:00 PM Surveyor interviewed DOH AA and Regional Nurse Q. DOH AA and Regional Nurse Q stated they did not have follow up documentation and stated what they had learned from this survey is the importance of documentation. DOH AA and Regional Nurse Q stated would be re-educating their team on documentation moving forward.	N 431		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire	N 525		

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N 525	Continued From page 23	N 525		

evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not conduct at least one fire evacuation drill annually that simulates the conditions during usual sleep hours during calendar year 2023 and a fire drill in the 4th quarter of calendar year 2023.

This is a repeat deficiency and being cited for the third time. See Statement of Deficiency (SOD) W0M011, dated 10/22/2020, and SOD W0M013, dated 10/25/2022.

Findings include:

On 05/02/2024, Surveyor requested to review fire evacuation drills for calendar year 2023. Facility completed fire drills on 04/07/2023, 08/28/2023 and 09/22/2023. Facility did not conduct a fire drill in the 4th quarter of calendar year 2023.

On 05/02/2024 at approximately 10:00 AM, Surveyor asked DOH AA if any of the fire drills were simulated during usual sleep hours. DOH AA looked at fire drills and stated there was not a simulated drill during usual sleep hours and s/he would let maintenance know.

On 05/08/2024 at approximately 2:00 PM, Surveyor interviewed DOH AA and Regional RN

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N 525	Continued From page 24 Q. Both acknowledged at least one fire evacuation drill should have been completed during usual sleep hours annually and during the 4th quarter of calendar year 2023. DOH AA stated after Surveyor's visit, s/he had maintenance conduct them immediately on the same day of the survey.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct other evacuation drills at least semi-annually for calendar year 2023. This is a repeat deficiency and being cited for the third time. See Statement of Deficiency (SOD) W0M011, dated 10/22/2020 and SOD W0M013 dated 10/25/2022. Findings include: On 05/02/2024, Surveyor requested to review other evacuation drills for calendar year 2023. There was no evidence of other evacuation drills for calendar year 2023. On 05/08/2024 at approximately 2:00 PM, Surveyor interviewed Executive Director A and Regional Nurse B if there were any other evacuation drills conducted in calendar year 2023. Executive Director A stated, "No," but moving forward s/he would ensure the drills were conducted semi-annually.	N 526		

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