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COTTAGES AT LAKE PARK (THE)	2006 LAKE PARK DRIVE MARINETTE, WI 54143

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N 000	Initial Comments On 10/03/2024 with additional information gathered through 11/19/2024, Surveyors conducted a complaint investigation at The Cottages at Lake Park. The complaint was substantiated. As a result of the investigation, 2 deficient practices were identified. Census: 26	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure they immediately conducted an investigation when an allegation of abuse was brought to their attention. The provider	N 158		

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

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N 158	Continued From page 1 was made aware by Adult Protective Services (APS) that there were concerns regarding caregiver misconduct due to bruising of unknown origin being found on Resident 1 while under their care. The provider did not conduct an investigation into the allegation when initially made aware. The investigation was not completed until after the provider was made aware of the requirement and directed to complete an investigation by Department on 3 separate occasions. The investigation was conducted 74 days after the provider was initially made aware of the allegation. Findings include: On 09/16/2024, the Department received a complaint alleging the provider did not conduct an internal investigation into a reported abuse allegation. On 10/03/2024, Surveyor interviewed RN B at 11:45 AM with Manager C joining at 12:15 PM. RN B stated APS had been to the facility on 09/06/2024 and had a meeting with RN B and Manager C present. RN B stated at the end of the meeting the APS investigators made RN B and Manager C aware of 2 allegations, 1 being that Resident 1 had bruising of unknown origin on his/her body (discovered at the hospital on 08/21/2024) that had occurred while in their care, alleging caregiver misconduct as the cause. Surveyor asked to review a copy of the internal investigation into the allegation. RN B stated to his/her knowledge no internal investigation had been conducted as no specific caregiver had been accused and the allegation was brought to their attention after the resident had already been discharged from the facility. After review of the allegation and code with both RN B and Manager	N 158		

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N 158	Continued From page 2 C, RN B acknowledged all allegations of caregiver misconduct must be investigated even if no specific caregiver is listed or the resident is no longer at the facility, to ensure current resident's safety. The provider was made aware of the allegation on 09/06/2024 and had 7 days to conduct an investigation. Additionally, it was reviewed per DHS13.05(3)(a) all allegations of caregiver misconduct must be reported to the Office of Caregiver Quality (OCQ) regardless of the internal investigation's conclusion. RN B and Manager C discussed moving forward by ensuring the investigation into the allegation and any required reporting was completed. Surveyor requested a copy of the investigation once completed and to be notified when the provider completed the reporting by including Surveyor in the e-mail to OCQ. On 10/18/2024, Surveyor received and reviewed Resident 1's hospital record including the skin assessment on 08/22/2024 that noted multiple scattered bruises were found on Resident 1's body in "various sizes and stages of healing." As of 10/22/2024, no documentation or communication was received indicating the investigation was completed and reported to OCQ. On 11/14/2024 at 9:00 AM, Surveyors conducted an exit conference with Administrator A, RN B, and Manager C. Surveyor reviewed findings that no investigation had been completed, reported, or submitted for survey review. Manager C questioned what allegation they did not investigate. Surveyor reviewed the allegation of caregiver misconduct related to the bruising found on the resident initially reported to the provider by APS on 09/06/2024 and discussed	N 158		

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again with the provider on 10/03/2024. Manager C indicated s/he only knew about the allegation of the resident being on the floor for 2 hours and the resident's foot being ran over (neither of which had documentation of a completed investigation.) Manager C and Administrator A stated they don't get the exact allegations from APS. Surveyor reviewed that RN B had brought forward the APS concern to the Surveyors and discussed the allegation of bruising on 10/03/2024. RN B was aware APS alleged bruising on the resident (found when the resident went to the hospital) and no investigation was completed. RN B then recanted, "I didn't know about the bruising until you (Surveyors) reported it to me." Surveyors reviewed notes on what was said by RN B during the onsite visit on 10/03/2024 quoting RN B stating no investigation was completed regarding the allegations of bruising because "the resident wasn't living here anymore," and it "wasn't about a specific caregiver." RN B then stated, "I do remember that now ... Maybe I missed remembering that." Surveyor reviewed that during the onsite visit on 10/03/2024 it was also discussed that the investigation into the bruising needed to be completed retroactively, reported to OCQ, and submitted to the Department for survey review. Manager C denied being part of the conversation. RN B stated, "I wasn't aware I could retroactively conduct an investigation." Surveyors reviewed the discussion had on 10/03/20204 with Manager C, RN B, and both Surveyors present where the codes, the providers responsibility to still conduct an investigation, the reporting process, and submission for survey review were discussed. Administrator A then stated, "So [Surveyor] what you are saying is even if the resident was gone the investigation had to take place." Surveyor reconfirmed an investigation is still required by the code. The

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N 158	Continued From page 4 provider is responsible for being aware of the code requirements and conducting an internal investigation into all allegations brought to their attention. In subsequent e-mail communication between Manager C and the Department between 11/18/2024-11/19/2024 Manager C questioned again if an internal investigation needed to be completed regarding the allegations and was told a 3rd time it is the providers responsibility to conduct an internal investigation into all allegations of caregiver misconduct. In subsequent e-mail communication between Manager C and the Department between 11/18/2024-11/19/2024 Manager C questioned if an internal investigation needed to be completed regarding the allegations. On 10/03/2024, 11/14/202, and on 11/19/2024, provider's responsibility to conduct an internal investigation into all allegations of caregiver misconduct was reviewed. On 11/19/20204, an internal investigation was completed and submitted to the Department on 11/20/2024 for survey review. The internal investigation concluded no abuse occurred and stated therefore the provider believed it was not required to be reported to the Office of Caregiver Quality despite the discussion held on 10/03/20204 when reporting requirements were reviewed. The investigation was conducted 74 days after the provider was initially made aware of the concern and was not reported to OCQ. Cross reference N0353 DHS 83.32(3)(i) Rights Of Residents: Adequate Treatment	N 158		

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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. The provider was aware while on hospice services Resident 1 was found to be positive for a urinary tract infection (UTI.) During a period of 9 days while being positive for infection, the provider did not ensure the care plan, all communication, or records were documented and kept up with the various changes in condition Resident 1 experienced from the time of detection to discharge. The provider did not maintain a complete record of the change in condition, the record from the outside health management or the communications between the provider and health management. The provider did not have changes in the care plan to provide interventions for the infection and its progression to manage changes in condition. The resident waited for 9 days without treatment of the infection or associated symptoms. The provider did not advocate for the resident to ensure outside health management provided prompt and adequate treatment to the resident. Without prompt or adequate treatment, the resident began to transition to actively dying and required emergent hospitalization.	N 353		

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N 353	Continued From page 6 This is a third repeat violation. See Statement of Deficiency KBNI11 (dated 11/22/2021) and GBP912 (dated 07/26/2023.) Findings include: On 09/16/2024, the Department received a complaint alleging a resident on hospice services had an infection that was left untreated and resulted in the need for hospitalization. On 10/03/2024, Surveyor reviewed Resident 1's record including the providers observation notes (OB N,) Individual Service Plan (ISP,) Medication Administration Record (MAR,) and Task Administration Record (TAR). Additionally, Surveyor reviewed Resident 1's Hospice Record (HR) and hospital medical records (MR) which Surveyor obtained from the hospice and hospitals as they were not included in the provider's record for Resident 1. Resident 1 was admitted the facility on 12/11/2023 from the sister RCAC program on campus. Resident 1's diagnoses include Alzheimer's disease, chronic diastolic heart failure, pan lobular emphysema, hypertensive chronic kidney disease, complex regional pain syndrome, and chronic obstructive pulmonary disease. Resident 1 began hospice services on 04/23/2024. Resident 1's ISP (undated) noted Resident 1 required a 1 assist for transfers and 2-hour toileting. Resident 1's primary medical provider was Nurse Practitioner (NP) A. Resident 1 had a standing order for UTI screening. Resident 1 had multiple allergies to medications but had a history of receiving Keflex antibiotic with no adverse outcomes. On 10/03/2024 at approximately 9:10 AM, Surveyor interviewed RN B with Manager C and Executive Director D joining at approximately	N 353		

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N 353	Continued From page 7 9:25 AM. RN B stated s/he recalled Resident 1 tested positive for a UTI on approximately 08/12/2024. RN B stated Resident 1 had multiple allergies to antibiotics and that there was a need to clarify culture and sensitivity (C&S) and susceptibility orders for the resident before NP A would prescribe an antibiotic. RN B stated s/he was aware the medication had not been ordered until approximately 8/20/2024. RN B stated s/he recalled the resident had a change in condition on approximately 8/17/2024 but stated that this was "not out of the ordinary" for the resident as s/he had had days previously where s/he had been lethargic in the past. RN B gave no indication that the hospice RN had provided him/her with education that this change in condition was not congruent with previous occurrences as this change was associated with an acute infection (noted in HR review.) RN B stated by the time the medication was started on 08/20/2024, the resident's change in condition was significant enough that hospice services believed s/he was beginning to pass away. RN B stated s/he recalled on 8/21/2024 the family requested Resident 1 be brought into the emergency department for lifesaving treatment. RN B stated all required documentation for health monitoring during the changes of condition would be noted in the provider's copy of the resident's record. Manager C stated occasionally the hospice provider would include a note in the facility OB N and that the facility relied on the OB N, MAR, and TAR for the required health monitoring and change in condition documentation in the resident record. Change In Condition/ Health Monitoring Communication And Documentation Surveyor reviewed the resident record to review	N 353		

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the required documentation for changes in condition and health monitoring.

On 10/03/2024, Surveyor reviewed Resident 1's OB N and noted there was an entry on 08/12/2024 about Resident 1 having a change in condition and needing a urine test for a possible UTI. There was an entry on 08/13/2024 noting family alleged no one checked on the resident or offered him/her to go to the bathroom since 3 PM (note written at 8:00 PM) and indicated Resident 1 informed his/her Family Member E that s/he had an infection. The next observation note is on 08/17/2024 when a significant change in condition was noted and it was documented that hospice was called. The next set of entries was on 8/21/2024 where hospice and the provider note that the patient appears to be transitioning to actively dying, noting Resident 1 was in bed, lethargic, not answering questions appropriately, O2 86%, Cheyenne Stokes respirations at times, and s/he was unable to close his/her mouth or swallow liquids. A note on 8/21/2024 at 3:45 PM by RN B noted hospice believed the resident was actively dying while the family was present and upset. The note indicated the resident did not start treatment for UTI until 8/20/2024, stating the provider had been waiting for a C&S due to numerous allergies. The note additionally indicated NP A stated the resident could be sent to the emergency department to check for sepsis. The resident was sent out to the hospital at approximately 4:00 PM on 08/21/2024. The resident was known to have an infection on 08/13/2024 and did not have documentation detailing the changes in condition or health monitoring in the OB N on 08/14, 08/15, 08/16, 08/18. 08/19 or 08/20.

On 10/03/2024, Surveyor requested to review the

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most recent ISP for Resident 1. Surveyor was provided a copy that contained no signatures or dates of completion. The ISP did not contain evidence that the plan had been updated to manage Resident 1's positive diagnosis of a UTI on 08/13/2024 or any associated interventions for managing the infection or its symptoms. The ISP did not reflect the changes in the resident's condition to accurately reflect the current needs or give caregivers a clear plan for treatment based on Resident 1's deteriorating condition.

On 10/03/2024, Surveyor interviewed RN B and Manager C at approximately 12:15 PM. RN B confirmed the copy of the ISP was the most recent ISP for Resident 1. RN B stated s/he did not believe the ISP had been updated to reflect a current plan put in place to manage Resident 1's UTI and changes in condition between 08/12/2024-08/21/2024. Manager C stated the ISP was not changed as it was the hospice plan of care that the provider had been relying upon to ensure change of condition monitoring and interventions. Surveyor requested to review the hospice plan of care. Manager C and RN B stated they did not have a copy or access to the hospice plan of care or hospice notes. RN B stated hospice and NP A would give him /her a verbal update when they visited but that they did not request or keep the NP visit notes, hospice notes, or hospice plan of care for the resident's record. The provider did not document communication with the medical provider or other health care providers and did not record all changes in the resident's health as is required. Neither RN B nor Manager C could account for the discrepancy of stating their required change in condition documentation and plan was completed by hospice within the hospice notes, yet they did not have the hospice notes. Manager C stated

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evidence of health monitoring for the change in condition could be found in the TAR.

Surveyor reviewed the TAR and noted no interventions had been added to monitor for changes in condition after the resident was diagnosed with a positive UTI on 08/13/2024. The only notation of difference was 1 additional set of vital signs was taken on 08/17/2024, however the scheduled set of vitals for 08/06/2024 and 08/20/2024 was left blank. When the lack of interventions specific to the change in condition documented in the TAR was brought to Manager C's attention (during the interview on 10/03/2024 at approximately 12:15 PM) Manager C reiterated that the health monitoring interventions for the change in condition would have been completed and documented by hospice. Both RN B and Manager C were unable to verify this as they both stated they had not reviewed the hospice notes or plan of care and did not have a copy of them available for the caregivers at the time of the change in condition or currently in the resident's record for review. RN B stated the hospice service came to the facility with a caregiver to assist with bathing for the resident and an RN assessment 2X a week. RN B acknowledged, apart from the limited time when hospice was at the facility, the provider was still responsible for providing cares for the resident for the majority of the day. RN B stated apart from the hospice plan and documentation, which was not at the facility or available for the caregivers to review, the only other documentation was what was in the resident OB N, MAR, and TAR.

On 10/03/2024 Surveyor requested the provider send all the documentation they had for Resident 1 from 08/01/2024 - discharge on 08/21/2024, including any hospice records. On 10/03/2024 at

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N 353	Continued From page 11 2:15 PM, Surveyor received an e-mail from Manager C that included some of the requested documentation. Surveyor reviewed the provider's hospice policy and procedure. The procedure noted, "...Hospice staff will need to ask for documentation binders for their patients..." Manager C confirmed no hospice records were at the facility, despite their own policy and procedure indicating hospice was to document in a hospice binder for the resident. Manager C noted, "... As far as any additional health monitoring from the 17-21/hospice documentation; you are going to need to obtain that from Bristol hospice and [NP A's] office at Bellin as we do not have their documentation. We would only have our TAR, observations and MAR from those dates ..." On 10/03/20204, Surveyor requested records from the hospice provider. Surveyor reviewed the Hospice Record (HR): 08/12/2024 2:31 PM, "[Resident 1] has been a 2-person hard pivot the past two days and has had frequency in urination going 5x in one hour ... an easy stand lift was ordered ... [Resident 1] color is pale/yellowish and diaphoretic. [Resident 1] reports burning with urination and believes that [s/he] has a UTI ... Shortness of breath at rest during visit prior to activity which is new this visit ... At rest in wheelchair during visit, heavy breathing ... unable to transfer with 2 staff. EZ stand ordered ... discussed POC [Plan of Care] with facility nurse and med tech." 8/14/2024 11:59 AM, "Pt [sic] is EZ stand now [sic] not able to assist with transfers." 8/17/2024 11:04 AM, "Recd [sic] call regarding patient lethargy and weak vital signs. Requested O2 placement overnight, [sic] vitals improved. Arrived to find patient in bed, still lethargic. Skin is	N 353		

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N 353	Continued From page 12 warm and mildly diaphoretic. O2 was not in place-replaced ... updated staff to administer Tylenol fluids and maintain 02 ... skin warm/ pale ... bounding heart sounds." 08/21/2024 2:09 PM, " ... UA results positive MD notified 08/19/2024 ... patient had COC overnight. [S/he] has been in bed all day, not eating, unable to take medications. Writer arrived to find patient in bed, diaphoretic, lethargic, Cheyenne Stokes respirations. Appeared patient is transitioning to actively dying. 02 sat below 90, HR rising to tachycardia, febrile ... Collaborated with facility nurse [RN B] who reports patient has days where [s/he] lays in bed and is tired and the next day bounces back. Writer educated [RN B] that the way patient is presenting [him/herself] that is not the case this time ... Writer attempted to give water and patient is unable to close mouth or swallow, all liquid ran out of [his/her] mouth and [s/he] coughed ... Writer called PCP office 4x with no answer to update on need for PRN morphine as patient is not able to swallow. Hospice MD was then contacted to fill medication in order for pharmacy to be able to deliver medication before they closed after 4:00 PM. After 4th attempt PCP office called writer back and writer gave an update on condition. 30 minutes after writer left facility, writer received a phone call from the facility that the PCP gave orders to have the patient seen in the ER for work up for possible sepsis related to [his/her] recent UTI ..." The provider did not have correlating documentation, health monitoring plan, or interventions in the resident's MAR, TAR, OB N, or ISP for all the changes noted in the HR. The provider's documentation did not reflect all of the changes that were note during the hospice visits and the provider did not put interventions into	N 353		

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	0017939	A. BUILDING: _____ B. WING _____	C 11/19/2024

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place to address the changes in condition in the resident record. The provider did not put a plan in place to facilitate health monitoring for the changes or plan for communicating the changes with their staff. The hospice notes were not available to staff for review or reference when hospice was not present.

Prompt And Adequate Treatment

On 10/03/2024 at approximately 9:50 AM, Surveyor conducted an interview with RN B and NP A. NP A stated s/he couldn't recall specifics but that s/he did recall Resident 1 had a positive UTI and that they had been waiting for the C&S and susceptibility results to come back before s/he was able to order a medication. NP A stated it was difficult as the resident was allergic to many antibiotics. NP A stated s/he could not recall exactly how many days since the UTI was confirmed that it took for Resident 1 to receive treatment, but that s/he recalled s/he was waiting for the results so s/he could order a narrow spectrum antibiotic that the resident could tolerate. NP A stated s/he recalled the resident had a change in condition around the time the medication was ordered, that the resident had begun to actively pass away, and that the family wanted him/her to be seen in the emergency department. NP A stated s/he was aware the resident may have been septic from his/her infection and stated that many residents pass away from sepsis who are on hospice as the families may choose not to treat the infections. NP A then acknowledged that this was not the families' wish for Resident 1 as they wanted lifesaving treatment that required emergency hospitalization.

On 10/14/2024 at 11:49 AM, Surveyor interviewed

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POA F. POA F stated Resident 1 had been increasingly ill for a week prior to being diagnosed with at UTI on 08/13/2024. POA F stated after Resident 1 was found to have a UTI s/he was "left untreated and suffering for days" POA F stated s/he was aware the PA needed to check on which medications would work best for the resident but stated the Resident's symptoms were not being monitored or cared for by the provider while s/he waited for treatment. The POA stated the provider did not advocate for the resident and by the time a medication was finally ordered by NP A (on 08/20/2024) the resident was beginning to die from the infection. POA F stated the provider waited too long to get the resident treatment with antibiotics all the while stating it was due to the results not coming back timely. POA F stated it felt as though "everyone" was just ok with "letting [Resident 1] go" and that it was not the families plan to let the resident pass away from a treatable infection.

Surveyor reviewed the provider's resident record, emergency department records, and laboratory documentation for the UTI and subsequent treatment timeline:

8/12 Resident 1 is suspected of having a UTI. Hospice requests the facility collect a urine sample per NP A's standing orders.

8/13 A urine sample was brought to Bellin laboratory and initial positive UA results were faxed to the provider.

8/14 The urine analysis (UA) results with C&S was completed.

8/15 The urine analysis (UA) results with C&S was sent to the provider. NP A's office requested

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susceptibility testing and was told by the lab it would be ready on 8/17/2024 (Saturday.) The provider had a copy of the fax record and was also made aware the results would be ready on 8/17/2024.

8/17 The provider documented a significant change in Resident 1's condition and contacted hospice as the resident became lethargic and began to slur his/her words.

The susceptibility results were completed at 6:18 AM and entered into EPIC by the lab for review. The provider was aware the results were due back today and did not follow-up with the lab, Hospice, or NP A's office to ensure prompt treatment even after noting the significant change in condition.

8/18 No correspondence from the provider to the lab, hospice, or NP A's office.

8/19 No correspondence from the provider to the lab, hospice, or NP A's office.

8/20 At 1:09 PM, NP A acknowledged the susceptibility results in EPIC and ordered the broad-spectrum antibiotic Keflex which s/he noted s/he was aware the resident had safely been on before.

8/21 Resident 1's family was told the resident is actively dying and the family requested the resident receive adequate treatment. NP A noted the resident's family may want him/her "checked out at the emergency department to do a work-up for potential sepsis from UTI."

The hospital records note the resident presented to the hospital with weakness and fever stating

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s/he "hurts all over." Resident 1 was admitted to the hospital and treated for sepsis and pneumonia. The hospital was able to promptly diagnose and began treatment for the dual infections on the day of admission 08/21/2024. The hospital record notes, "At the time of admission, patient was quite ill, admitted to inpatient ... patient had faster than expected recovery ..." With prompt and adequate treatment in the hospital, Resident 1 did not pass away, and was discharged from the hospital on 08/28/2024 to an alternate provider's care.

On 10/03/2024 Surveyor interviewed RN B at approximately 11:45 AM. RN B could not account for why the provider did not follow-up with the lab to receive the results of the susceptibility test on 08/17/2024 when they knew the results would be back and the resident had had a significant change of condition that day. RN B stated, "I don't feel it's my place to ask [NP A] why it was taking so long." After further discussion RN B acknowledged the provider's role as the main health care provider and responsibility to advocate for their residents.

The provider did not ensure prompt treatment as they did not follow up with the lab, hospice, or NP A when they knew the laboratory results were going to be back on 08/17/2024. Due to the resident not receiving prompt treatment, when the antibiotic (Keflex- which had not required additional days of testing as it was broad spectrum and already known to be safe for the resident) was finally given to the resident 9 days later, it was no longer adequate to treat the infection as s/he had become septic, developed pneumonia that was undiagnosed and untreated, and now required IV antibiotics and hospitalization. The family advocated for the

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N 353	Continued From page 17 resident and sought out adequate treatment for the resident at the hospital to save his/her life from a treatable infection that had been allowed to progress into sepsis and undiagnosed pneumonia. Left untreated, the resident had been transitioning to actively dying as a direct result of the provider not ensuring the resident received prompt or adequate treatment. Cross reference N0161 DHS 83.12(3)(a)Investigate Injuries Of Unknown Source	N 353		