STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013688	A. BUILDING: _____ B. WING _____	R-C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORAINE RIDGE	**2929 SAINT ANTHONY DR GREEN BAY, WI 54311**

(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
{U 000}	INITIAL COMMENTS On 08/28/2024 and 09/04/2024, Surveyor conducted 3 complaint investigations, a standard survey and a verification visit at Moraine Ridge. Additional information was gathered through 09/06/2024. All 3 complaints were substantiated. Five of six previous deficient practices were corrected. As a result of the survey and investigations, 5 deficient practices were identified. One of the five deficient practices identified was a recite. Under statutory provisions, a $200 revisit fee is being assessed for the follow-up licensing visit. Census: 50	{U 000}		
U 114	89.23(1) SERVICES GENERAL REQUIREMENT. A residential care apartment complex shall provide or contract for services that are sufficient and qualified to meet the care needs identified in the tenant service agreements, to meet unscheduled care needs of its tenants and to make emergency assistance available 24 hours a day. This Rule is not met as evidenced by: Based on observation and interview the provider	U 114		

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

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did not ensure Tenant 1's care needs were met. The provider did not provide services sufficient to meet Tenant 1's care needs for toileting assistance or housekeeping to maintain a safe and clean environment.

Findings include:

On 09/03/2024, the Department received a complaint alleging tenant care needs were not being met.

On 09/04/2024 at 10:07 AM, Surveyor interviewed Tenant 1's Family Member E. Family Member E stated Tenant 1 is his/her own person but has a diagnosis of dementia that requires frequent family and provider assistance. Family Member E stated Tenant 1's primary physician communicates directly to Family Member E as Tenant 1 is unable to manage his/her own medical care needs and it is Tenant 1's preference. Family Member E stated Tenant 1 enjoys his/her own independence however has difficulty with tasks involving decision making steps. Family Member E sated Tenant 1 will frequently have a bowel movement (BM) and is unable to take correct steps to ensure cleanliness. Family Member E stated s/he visits weekly and has noticed areas within the apartment where it appears BM has been accidentally smeared. Family Member E stated on 09/03/2024 s/he noticed what appeared to be dried BM on Tenant 1's chair in the living room, on a blanket in the bedroom, in the tub in the in the bathroom, and on the floor. Pictures 1, 2, 3, and 4. Family Member E stated s/he brought the concerns to Manager G's attention and Manager G stated s/he would have a caregiver take care of it. Family Member E stated at times it has been noticed that Tenant 1 will have what appears to

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be BM on his/her clothes when family comes to pick him/her up from the facility. Picture 5. Family Member E stated the family regularly finds Tenant 1's bed sheets stained, laundry unwashed in a pile, soiled depends left on the bathroom floor, and expired food in the refrigerator. Family Member E stated family will come weekly to change the sheets, go through the refrigerator, and at times do the laundry, as it is not being regularly maintained by the provider. Family Member E stated Tenant 1 has been unable to follow tasks and steps to maintain a sanitary apartment on an ongoing basis with increased need from when s/he was first admitted on 08/07/2023. Family Member E stated since Tenant 1's apartment has not been maintained in a sanitary condition that Tenant 1 had been hospitalized and diagnosed with norovirus twice within the last year.

https://www.cdc.gov/norovirus/causes/index.html How Norovirus Spreads | Norovirus | CDC (Retrieval dated 09/10/2024.)
" ...You can get norovirus by accidentally getting tiny particles of feces (poop) or vomit in your mouth from a person infected with norovirus.

If you get norovirus illness, you can shed billions of norovirus particles that you can't see without a microscope. It only takes a few norovirus particles to make you and other people sick ...

Norovirus is very contagious and spreads very easily and quickly in different ways ..."

On 09/04/2024, Surveyor reviewed Tenant 1's hospital discharge paperwork and noted Tenant 1 had been diagnosed with norovirus and hospitalized from 12/22/2023-12/27/2023 and diagnosed with norovirus again on 04/29/2024

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U 114	Continued From page 3 during an emergency room visit. On 09/04/2024 at 12:19 PM, with Tenant 1's permission, Surveyor observed Tenant 1's apartment with Administrative Coordinator F present. Surveyor observed a dried brown BM-like smear on Tenant 1's chair in the living room, debris/ dirt in the tub in the main bathroom, light brown smears on the shower curtain leading to the tub and wall above the towel bar in the main bathroom, a pile of what appeared to be unwashed laundry in Tenant 1's bedroom and a soiled Depends on the floor of Tenant 1's bathroom leading from the bedroom. Pictures 6, 7, 8, 9, 10, and 11. Administrative Coordinator F acknowledged all the observations while in the apartment. On 09/04/2024 at approximately 12:45 PM, Surveyor interviewed Administrator A. Administrator A stated s/he was aware of Tenant 1's diagnoses and need for assistance with cleanliness and tasks related to toileting, but stated s/he was unaware the issues were ongoing. Administrator A stated laundry and housekeeping services are typically completed once per week but are done more frequently when needed. Administrator A reviewed and acknowledged the pictures of areas to be addressed in Tenant 1's apartment. Administrator A acknowledged the continued need to assist Tenant 1 with unscheduled care needs such as regularly assisting with personal hygiene after toileting and housekeeping as needed throughout the week to keep the apartment clean and sanitary. At approximately 1:30 PM Administrator A stated s/he spoke with Manager G and confirmed Family Member E told Manager G about the BM on	U 114		

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U 114	Continued From page 4 Tenant 1's chair a few days prior. Administrator A stated Manager G delegated the task to the caregivers at the time but could not say why it was not completed or who the caregivers asked by Manager G to complete the task were. Cross Reference U0127 DHS 89.23(3)(f) Services U0269 DHS 89.34(18) Tenant Rights	U 114		
U 127	89.23(3)(f) SERVICES SERVICE QUALITY. Meals and snacks served to tenants shall be prepared, stored and served in a safe and sanitary manner. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure food was stored in a sanitary manner. The refrigerator and food storage areas were not safely and sanitarily maintained. Findings include: On 08/28/2024 at 10:43 AM, Surveyor toured the facility kitchen with Manager G, Cook H, and Cook I present. Surveyor observed the refrigerator where resident food was kept was not clean. Surveyor observed a reddish brown dried blood-like puddle on the floor and down the side of a metal storage cart. (Photo 12.) Surveyor observed food items (a half a lemon, a tomato, an unidentified wrapped food item, and multiple unidentifiable food scraps/ debris) on the floor that appeared to be in various states of	U 127		

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decomposition. (Photo 13.) Surveyor observed dried spills on the floor, walls and storage carts. (Photos 12, 13, and 14.) Manager G and Cook H both acknowledged the observations.

Surveyor observed an attic space with steps up from the kitchen that was being used as a food storage area. The attic space was observed by Surveyor, Manager G, Cook H and Cook I to be uncomfortably warm. Cook H expressed concerns about the temperature the food was being stored in and stated s/he had discussed his/her concerns with Executive Director A but had not been given direction to discontinue using the food stored in the attic space. Cook H pointed out items such as chicken broth that had not yet expired but s/he was concerned had been stored in too high of a temperature to be safe to consume. (Photo 15.) Cook H pointed out mustard and stated when s/he opened the product to serve it, it had been "warm and separated" and stated s/he was worried about the safety of serving the mustard.

Surveyor observed cardboard boxes of baking mix on shelves that had animal feces on top. (Photos 16 and 17.) Surveyor observed spilled dried goods on the shelves with dark particles present. (Photo 18.) Surveyor observed a mouse trap and rodent feces on the floor. (Photos 19, 20 and 21.)

Surveyor observed a ventilation panel leading to the kitchen and food storage areas covered in debris. (Photo 22.)

During the tour Surveyor interviewed Cook H. Cook H stated s/he was recently hired and had found the kitchen to be maintained in unsanitary conditions. Cook H showed Surveyor areas of the

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kitchen s/he had had time to begin deep cleaning and acknowledged the refrigerator and food storage areas were not sanitary. Cook H stated with the number of residents, 3 meals a day and snacks there was not enough time during the shift or staff available to help to clean.

At 2:30 PM Surveyor interviewed Administrator A. Administrator A stated the staff had "taken care of" the identified sanitation concerns in the refrigerator. At 2:36 PM Surveyor toured the kitchen with Administrator A and observed the walk space of the floor and the dried blood-like spill had been mopped however the areas under the storage carts had not been cleaned as it still had spilled food and the decaying wrapped food item, lemon, and tomato were still present below the food storage shelves. Administrator A stated s/he would have the staff remove the food shelves and sanitize the whole refrigerator.

When touring the attic with Administrator A s/he acknowledged the observations of the food being stored in the warm attic space and the dried stored food in boxes and spilled with animal feces on top. Administrator A stated the facility had had issues with mice and had pest control at the facility monthly. Administrator A stated s/he had intentions of discarding all of the food that had been stored in the attic but had not "gotten around to it yet."

On 09/04/2024 at approximately 12:00 PM, Surveyor returned to the facility and observed the refrigerator and attic food storage space had not been corrected by the provider.

At approximately 12:45 PM, Surveyor interviewed Administrator A. Administrator A stated to his/her knowledge the refrigerator had been cleaned.

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U 127	Continued From page 7 Administrator A reviewed photos of the refrigerator taken during the observation from earlier that day (09/04/2024) and acknowledged the refrigerator was still not cleaned, and the attic still contained dry food items that were not being sanitarily stored. (Photo 23.) Administrator A stated s/he had planned on having assistance with the tasks on 09/05/024 as s/he had been busy the prior week and had not addressed the concerns in the kitchen. Administrator A acknowledged continuing to allow resident food to be stored in unsanitary conditions in the refrigerator posed a potential health risk to the tenants. Administrator A denied the food being stored in the attic as a health risk as s/he no longer had the intention of the food being served to tenants. When asked if all staff were aware that the food stored in the attic was no longer to be served, Administrator A stated the cooks were aware. Administrator acknowledged that when cooks were not present the staff may be responsible for providing residents with food and snacks and the staff were currently unaware that food items stored in the attic were not to be served. Cross Reference U0114 DHS 89.23(1) Services	U 127		
{U 129}	89.23(4)(a)2. SERVICES PROVIDER QUALIFICATIONS. Service Providers. Nursing services and supervision of delegated nursing services shall be provided consistent with the standards contained in the Wisconsin nurse	{U 129}		

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{U 129}	Continued From page 8 practice act. Medication administration and medication management shall be performed by or, as a delegated task, under the supervision of a nurse or pharmacist. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure medication management met the standards of practice. Schedule II medication were not stored in a secured manner and medication cards containing Private Health Information (PHI) was not disposed of in a manner that protects the tenants' privacy. This is a repeat deficiency. See Statement of Deficiency (SOD) X50W11 dated 10/27/2023. Findings include: On 08/28/2024 at 11:18 AM, Surveyor toured the medication room with Manager G present. The medication room was open to entry and contained 2 medication carts that were secured against unauthorized access with locks. Upon review of the medication destruction process Surveyor was shown a lock box mounted to the wall. Manager G stated medication waiting to be destroyed would be dropped into the secured box to wait for 2 staff to destroy them. The mounted box contained only 1 lock. Manager G acknowledged any Schedule II medications require a double lock while being stored waiting for destruction. Surveyor observed a unlocked cabinet in the room and discovered medication bubble packs within the unsecured cabinet. One bubble pack	{U 129}		

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{U 129}	Continued From page 9 was labeled with Tenant 3's information and morphine tablets. The bubble pack was empty of the medication. The 2nd bubble pack was labeled with Tenant 4's information and hydrocodone tablets. The bubble pack contained 27 tablets of hydrocodone. Manager G had no explanation for why the schedule II medication packs were not secured. Manager G acknowledged the risk for potential misconduct and medication diversion. While reviewing the medication destruction process Manager G stated the staff would " black out" the tenant's PHI from the medication bubble packs prior to discarding them. Surveyor observed an example of the blacked-out information and observed the tenant PHI was still clearly visible. Manager G acknowledged the PHI was still accessible through the blackened-out marker and that the provider would need to ensure the PHI was appropriately destroyed to protect tenant PHI and privacy.	{U 129}		
U 269	89.34(18) TENANT RIGHTS Rights of tenants. A tenant of a residential care apartment complex shall have all the rights listed in this section. These rights in no way limit or restrict any other rights of the individual under the U.S. Constitution, civil rights legislation or any other applicable statute, rule or regulation. Tenant rights are all of the following: (18) FREEDOM FROM ABUSE. To be free from physical, sexual or emotional	U 269		

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abuse, neglect or financial exploitation or misappropriation of property by the facility, its staff or any service provider under contract with the facility.
This Rule is not met as evidenced by:
Based on record review and interview the provider did not ensure Tenant 2 was free from neglect. Caregiver C was present when Tenant 2 fell to the floor breaking his/her left hip. Caregiver C witnessed the fall, did not assist, and left Tenant 2 on the floor.

Findings Include:

On 03/26/2024, The Department received a complaint alleging caregiver misconduct including abuse and neglect.

On 08/28/2024 Surveyor reviewed Tenant 2's record and noted s/he was admitted to the facility on 01/23/2023. Tenant 2 was semi-ambulatory and required the use of a walker.

On 08/28/2024 at 1:52 PM, Surveyor interviewed Administrator A with RN B present. Administrator A discussed an incident that occurred on 10/28/2023 when it was reported that Tenant 2 had a fall that was potentially caused by Caregiver C and that Caregiver C, upon witnessing Tenant 2 on the floor, did not assist Tenant 2, and did not alert another staff member that Tenant 2 needed assistance before leaving the facility. Administrator A stated upon having the incident brought to their attention the provider immediately took steps to protect the tenants, conduct an investigation, and alert the police. Administrator A provided a summary of the internal investigation that was reported to the Office of Caregiver Quality and the Department.

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The investigation included caregivers' account of the event including statements that Tenant 2 had accused Caregiver C of pushing him/her causing him/her to fall after a second altercation/ argument transpired on the morning of 10/28/2023. The report included Caregiver C's denial of pushing Tenant 2 but remarks that s/he stopped Tenant 2 from hitting him/her with his/her walker by moving the walker which caused Tenant 2 to fall, but denied intentionally pushing the tenant. Caregiver C acknowledged leaving Tenant 2 while s/he was on the ground but stated s/he alerted another staff member (Caregiver J) that Tenant 2 needed assistance prior to leaving the facility. The report notes Caregiver J denied being made aware by Caregiver C that Tenant 2 had fallen and was in need of assistance.

The internal investigation did not have a consistent timeline as it relied on some caregiver approximations. The approximate timeline was created by reviewing the provider's internal investigation, Administrator A's interviewed account of the events, the police report, and an interview conducted with Tenant 2 and Family Member K on 09/06/2024 at approximately 11:05 AM:

Incident Timeline
10/28/2023:
7:23 AM (electronically recorded time)- the call light was initially responded to by Caregiver C who told the tenant s/he would be back shortly for cares.

8:08 AM (electronically recorded time)- the call light is responded to a 2nd time and it is presumed this is the time of the altercation according to Caregiver C's statements that when she came back a 2nd time the incident occurred.

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Between 8:08 and 8:28 Caregiver C stated s/he alerted Caregiver J s/he was leaving and that Tenant 2 was in need of assistance. (Caregiver C's stated timeline alleges this took place between 7:50 and 8:00 AM, which does not align with the known times from the call logs and punch cards.) Caregiver J stated s/he was made aware Caregiver C was intending to leave the building but had not been notified by Caregiver C that Tenant 2 was on the floor. (This is supported by the next call placed to Administrator A where s/he was informed Caregiver C left the job/ facility and it was not reported to Administrator A that Tenant 2 was on the floor as Caregiver J was unaware at the time the call was made.)

8:16 AM (electronically recorded time)- Per the police report, Family Member K stated s/he had 6 missed calls from Tenant 2.

8:28 AM (electronically recorded time)- Caregiver C punched out from work.

8:32 AM (Per police report)- 911 was called (caller not identified on the report.) Later reports indicate Tenant 5 as the caller as per Caregiver J s/he was not yet aware Tenant 1 had fallen or was in need of assistance.

8:33 AM- Compliance Officer D received a call from Administrator A who had been notified by Caregiver J that Caregiver C left the job/facility. (There was no mention of Tenant 2 being in need of assistance as it was not yet known by the caregiver (Caregiver J) left on site.)

8:36 AM- Compliance Officer D called Caregiver C who discussed a verbal altercation and Tenant 2 hitting Caregiver C with his/her wheelchair prior

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to Caregiver C becoming "very upset" and deciding to walk away and leave the job. (Caregiver C does not mention Tenant 2 had a fall or was in need of any assistance to Compliance Officer D at this time.)

8:46 AM- Per Caregiver J's statements, it was brought to Caregiver J's attention by other tenants that Tenant 2 was injured on the ground. Caregiver J immediately reported it to Administrator A as Tenant 2 was alleging Caregiver C pushed him/her. Per the police report, Caregiver J stated the paramedics arrived shortly after s/he notified Administrator A.

8:49 AM- After being notified about Tenant 2's discovered condition by Caregiver J, Administrator A notified Compliance Officer D.

9:20 AM- Compliance Officer D called multiple times and was finally able to get ahold of Caregiver J. Caregiver J stated at 8:46 AM other tenants informed him/her that Tenant 2 was injured on the ground and s/he immediately called for assistance, notified Administrator A, and assisted Tenant 2 until paramedics arrived to take him/her to the hospital for evaluation. Caregiver J stated s/he was not aware of how Tenant 2 fell but that Tenant 2 was stating Caregiver C pushed him/her down.

9:26 AM- Compliance Officer D called Administrator A who determined the police needed to be notified due to the new information that Tenant 2 had a fall, was injured, and was alleging Caregiver C pushed him/her.

9:34 AM- Compliance Officer D called Caregiver C and asked him/her to return to the facility. Compliance Officer D re-interviewed Caregiver C

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MORAINE RIDGE	2929 SAINT ANTHONY DR GREEN BAY, WI 54311

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with the new information that Tenant 2 had been found on the ground and was alleging abuse. During this 2nd interview Caregiver C admitted knowing Tenant 2 was on the ground and leaving, "This time [Caregiver C] said that [Tenant 2] was trying to beat [him/her] with [his/her] walker and [s/he] told [him/her] to stop but she wouldn't so [Caregiver C] 'moved the walker away from me'. [sic] When asked if [Tenant 2] was standing when [s/he] left [him/her] [Caregiver C] said [sic]no, [s/he] was on the ground.[sic]

[Compliance Officer D] then asked, [sic][S/he] was on the ground and you left [him/her]? [sic] And [sic][Caregiver C] said yes. When asked why [s/he] would leave [him/her], [Caregiver C] had no explanation, just going back to saying that [Tenant 2] was beating [him/her] with [his/her] walker. The Compliance Officer [Compliance Officer D] also asked why [s/he] hadn't said anything about [Tenant 2] being on the ground when [s/he] had talked to [him/her] earlier, and again [Caregiver C] had no explanation.

[Caregiver C] said on [his/her] way out [s/he] stopped and told [Caregiver J] that [Tenant 2] was on the ground. [Caregiver C] said this was around 7:50 to 8:00 AM. [Caregiver C] said [she] left the building after speaking with [Caregiver J]

When Compliance Officer [Compliance Officer D] followed up with [Caregiver J] [s/he] said that [Caregiver C] never told [him/her] that [Tenant 2] was on the floor. [S/he] said [s/he] didn't know until other residents told [him/her.]"

10:45 AM (electronically documented time in Police report)- Green Bay Police were dispatched to the facility and conducted interviews. After the

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interviews at the facility the police record notes the officer interviewed Tenant 2 at the hospital (time unknown.) The report notes, "[Tenant 2] confirmed that [s/he] initially stepped out of [his/her] room that morning to speak with [Caregiver C] for reasons concerning [Tenant 6's] pendant. [S/he] said that [Tenant 6] had not had a pendant since the day before because staff had taken it away to be fixed and that [s/he] was trying to speak to [Caregiver C] to inform [him/her] that [Tenant 6] needed to have the pendant because [s/he] was not able to call for help when [s/he] needed to. [Tenant 2] said that at this time [Caregiver C] got frustrated with [him/her,] had grabbed onto [his/her] walker and moved it out of [his/her] way but did not cause [him/her] to fall. [Tenant 2] said that [s/he] reapproached [Caregiver C] a few minutes later possibly sometime after 8:00 AM and said that [s/he] was trying to get [Caregiver C] the pendant again however [Caregiver C] became frustrated with [him/her] and pushed [his/her] walker forcefully so hard that [Tenant 2] lost [his/her] balance and fell to the floor. [Tenant 2] stated that this was done without [his/her] permission and caused [him/her] immediate significant pain to [his/her] left hip. [S/he] said that [s/he] was crying and yelling out for help and [Caregiver C] simply walked away from [him/her] without making any effort to help. [Tenant 2] said that [s/he] laid on the floor for several minutes and continued to yell for help and no other staff member attempted to assist [him/her.] [S/he] said that eventually other residents had come to check on [him/her] and asked [him/her] what happened and called 911 so that rescued come get [him/her] ..."

The report goes on to note that Caregiver C would be charged on 10/29/2024 with "Physical abuse of and [sic] elder person-reckless [sic]

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causing bodily harm state statue 940.198(3) felony" as well as "Negligently abusing a care resident state statute 940.295(3A) (3) which is also a felony."

10/29/2023:
8:15 AM- Caregiver C was arrested and charged.

On 09/06/2024 at approximately 11:05 AM, Surveyor interviewed Tenant 2 with Family Member K present. Although Tenant 2 had difficulty recalling specific of the events at times, s/he gave a statement that closely matched with his/her original statement given to the police on 10/28/2024. Tenant 2 expressed distress and anxiety related to recounting the events. Tenant 2 stated the foam padding on the front of the walker had sustained a tear caused by Caregiver C when s/he forcefully moved the walker. (Photo 24.)

Caregiver Background and Employment
During the interview on 08/28/2024 at approximately 2:20 PM, Administrator A discussed Caregiver C's employment history. It was discovered that Caregiver C had indicated on his/her Background Information Disclosure (BID) question 1 that s/he was awaiting 2 pending charges, yet the required additional details about the charges had not been written in by Caregiver C.

Surveyor reviewed Caregiver 's Department of Justice (DOJ) report and noted Caregiver C was convicted of 947.01 Disorderly Conduct on 02/19/2021, within 5 years of hire.

Administrator A stated s/he, nor any of the employees involved with the hiring process, contacted the Clerk of Courts to obtain the final

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disposition of the Disorderly Conduct charge or verify the pending charges indicated by Caregiver C on the BID. Administrator A was unable to state why Caregiver C was not asked to complete the BID as required with the additional information for the positive response to question 1.

Administrator A stated s/he was aware there were instances, prior to the incident on 10/28/2023, that occurred between Caregiver C and other tenants that had been reported. Administrator A stated Caregiver C did not always get along with all tenants.

Surveyor reviewed Caregiver C's employment history including a separate investigation that had been conducted on 10/19/2023:

Compliance Officer D:
"On Thursday, October 19th staff received complaints from a resident regarding the way [Caregiver C] was treating residents...

The complainant stated that [Caregiver C] was refusing cares to the residents telling [him/her] [s/he] did not have time...

...The complainant was then interviewed and stated there were 3 with the same caregiver and [s/he] named [Caregiver C] 3 days in a row. [S/he] said [Caregiver C] told [him/her] [s/he] wasn't going to get [him/her] dressed and another time got mouthy with [him/her.] [S/he] said if it was [his/her] kid [s/he] would have slapped [him/her] across the mouth ...

.. Compliance Officer [Compliance Officer D] felt that [the tenant's] timing may be off ... Because of this and because [the tenant's spouse] had no complaints and [the tenant's spouse] is always

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with [him/her,] the Compliance Officer [Compliance Officer D] feels that the incident may not have happened the way or when [s/he] states they did. The Compliance Officer [Compliance Officer D] felt it was probably more the way [Caregiver C] approached and the tone of [his/her] voice that upset [him/her] rather than actual neglect or mistreatment ...

The Compliance Officer [Compliance Officer D] then met with the employee [Caregiver C] at 1:15 PM on October 23rd, 2023. The Compliance Officer [Compliance Officer D] explained what the complaints were (not who they were from) and why we had to place [him/her] on unpaid leave. [Caregiver C] stated [s/he] understood. The Compliance Officer [Compliance Officer D] discussed different techniques [Caregiver C] could use when rushed because it seems that the incidents happened when [Caregiver C] felt rushed/overwhelmed with the workload. [Caregiver C] agreed that is what happens, and [s/he] will attempt to approach these issues with a better attitude in the future.

[Caregiver C] will return to work on October 24th at 7:00 AM."

Surveyor reviewed the internal investigation conclusion and noted a discrepancy in the findings that approach and tone of voice were not considered "actual neglect or mistreatment" yet the approach and tone of voice was deemed inappropriate enough that the provider felt Caregiver C required reeducation. Administrator A could not offer an explanation and stated the investigation had not been reported to OCQ or the Department. Caregiver C would reoffend a tenant 4 days after being allowed to resume employment.

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U 269	Continued From page 19 Cross Reference Z0010 DHS 50.065(2)(bb) Determine Final Disposition Of Charge	U 269		
Z 010	50.065(2)(bb) DETERMINE FINAL DISPOSITION OF CHARGE If information obtained under par. (am) or (b) indicates a charge of a serious crime, but does not completely and clearly indicate the disposition of the charge or the conviction, the department or entity shall make every reasonable effort to contact the clerk of courts to determine the final disposition of the charge. If a background information form under sub. (6) (a) or (am) indicates a charge or a conviction of a serious crime, but information obtained under 011 par. (am) or (b) does not indicate such a charge, the department or entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and the final disposition of the complaint. If information obtained under par. (am) or (b), a background information form under sub, (6) (a) or (am) or any other information indicates a conviction of a violation of s. 940.19 (1), 940.195, 940.20, 941.30, 942.08, 947.01, or 947.013 obtained not more than 5 years before the date on which that information was obtained, the department or the entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction relating to that violation.	Z 010		

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This Rule is not met as evidenced by:
Based on record review and interview the provider did not ensure 1 of 1 caregivers reviewed (Caregiver C) had a complete background check following the procedures in s. 50.065, Stats., and ch. DHS 12. Caregiver C was convicted of 947.01 Disorderly conduct within 5 years of hire and the provider did not make every reasonable effort to contact the Clerk of Courts to obtain a copy of the record as required.

Finding include:
On 03/26/2024, the Department received a complaint alleging caregiver mistreatment.

On 08/28/2024, Surveyor reviewed a Misconduct Incident Report (MIR) submitted by the provider on 11/01/2023 regarding Caregiver C's involvement in Tenant 2's fall on 10/28/2023, that resulted in significant injury. Surveyor reviewed additional investigation documentation that detailed the provider's immediate steps taken to protect the tenants, investigate the incident, notify necessary parties including immediately involving the police, and submit a timely self-report via the MIR system. The documentation noted Caregiver C was immediately terminated upon investigation into the incident.

On 08/28/2024, Surveyor reviewed Caregiver C's record and noted s/he was hired on 08/16/2023. Surveyor reviewed Caregiver C's Background Information Disclosure (BID) and noted Caregiver C marked "Yes" to the first question: "Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts? If yes, list each charge, when it occurred

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or the date of the charge, and the city and state where the court is located. You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents." Surveyor observed the required additional information for a positive answer to the question was not noted by Caregiver C. Caregiver C did not list each charge with associated date and city.

Chapter 12 notes, "If a Background Information Disclosure form, a caregiver background check, or any other information shows that a person was convicted of any of the offenses immediately below within 5 years before the information was obtained, the department, county department, child welfare agency, school board, or entity, as applicable, shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgment of conviction relating to that conviction."

Surveyor reviewed Caregiver 's Department of Justice (DOJ) report and noted Caregiver C was convicted of 947.01 Disorderly Conduct on 02/19/2021, within 5 years of hire.

On 08/28/2024, Surveyor interviewed Administrator A with RN B present at 2:20 PM. Administrator A stated s/he was in charge of hiring and obtain background checks for new employees as well as being in charge of other employees (including Compliance Officer D) who assist with the hiring process. Administrator A stated s/he was aware of the requirements to contact the Clerk of Courts. Administrator A stated s/he, nor any of the employees involved with the hiring process, contacted the Clerk of Courts to obtain the final disposition of the Disorderly Conduct charge or verify the pending

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Z 010	Continued From page 22 charges indicated by Caregiver C on the BID. Administrator A was unable to state why Caregiver C was not asked to complete the BID as required with the additional information for the positive response to question 1. Cross Reference U0269 DHS 89.34(18) Tenant Rights	Z 010		