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	0017539	A. BUILDING: _____ B. WING _____	C 11/04/2024

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N 000	Initial Comments On 10/10/2024, Surveyor conducted a complaint investigation at Clarity Care Cardinal. Additional information was gathered through 10/28/2024. An additional complaint was submitted and investigated on 11/04/2024. One of two complaints was substantiated resulting in 2 deficient practices. Census: 5	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 an investigation was completed when Resident 1 was found to have	N 158		

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

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injuries of unknown origin that indicated potential caregiver misconduct occurred. The injuries were not reported timely, leading to an internal investigation not beginning until 3 days after the discovery of the injuries. The investigation was not completed and did not take immediate steps to protect all residents. The investigation did not have all required documentation and did not report all caregivers involved as required.

Finding include:

On 09/24/2024, the Department received a complaint alleging the provider did not conduct a prompt investigation into a resident's injuries of unknown source.

On 10/10/2023, Surveyor reviewed Resident 1's records including the providers observation notes (OB N,) Individual Service Plan (ISP,) Incident Reports (IR,) Investigation Interviews (II,) Staffing Schedule (SS,) Medication Administration Record (MAR,) and Task Administration Record (TAR). Resident 1 was admitted on 08/26/2021 with diagnoses including Down's Syndrome, Atlantoaxial Instability, Obsessive Compulsive Disorder, and other conduct disorders. The Individual Service Plan (ISP) identified the resident as requiring full assistance for activities of daily living including being non-ambulatory, requiring a lift and some assistance to reposition him/herself.

On 10/10/2024 at approximately 9:30 AM, Surveyor interviewed Caregiver L with Caregiver M joining at approximately 9:50 AM. Caregiver L stated s/he was recently asked to start working at the facility because all the primary caregivers at the facility had been "pulled from the schedule" on 10/06/2024 due to an ongoing investigation.

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N 158	Continued From page 2 On 10/11/2024 at 9:01 AM, Surveyor interviewed Division Administrator (DA) B with Human Resources (HR) H joining at approximately 9:25 AM. DA B discussed the approximate timeline of events. DA B's interview along with review of Resident 1's medical record provided the following timeline of events: 09/20/2024- Team Lead A worked in the morning and reported not seeing any bruising on Resident 1. Caregiver's I and G worked the evening shift and did not report seeing bruising. Caregiver K arrived for the night shift at 9:00 PM. Caregiver K noticed bruising on Resident 1's eye upon arrival and stated s/he brought it to Caregiver I's attention. No caregivers documented any changes in condition or health monitoring in Resident 1's record. No caregivers notified management or the Resident 's care team. No caregivers sought assessment or treatment for the resident who was presenting with an unwitnessed head injury. 09/21/2024- Caregivers I and K worked. Caregiver K noticed red marks on the resident's arms and that the bruising on his/her eye was bigger and swollen. Caregiver I reported s/he had not been informed about the bruising by Caregiver K until 09/21/2024. No caregivers documented any changes in condition or health monitoring in Resident 1's record. No caregivers notified management or the Resident's care team. No caregivers sought assessment or treatment for the resident who was presenting with a swollen head injury. 09/22/2024- Caregivers I and K worked. No caregivers documented any changes in condition or health monitoring in Resident 1's record. No	N 158		

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caregivers notified management or the Resident 's care team. No caregivers sought assessment or treatment for the resident who was presenting with a swollen head injury.

09/23/2024- Caregiver K reported the bruising to Team Lead A at approximately 6:00 AM. Team Lead A reported the injuries to DA B at 8:45 AM. At 9:46 AM Team Lead A created an incident report and notified POA C and Resident 1's care team. At approximately 10:30 AM the provider began an internal investigation with HR J conducting staff interviews over the phone. No residents were interviewed. The provider notified Resident 1's MD by leaving a voice message. The provider did not seek assessment or treatment for the resident. The provider did not update the ISP or implement interventions for health monitoring based on the injuries/ change in condition. At approximately 1:00 PM, the MCO care team, including Care Manager MCO E, arrived at the facility and requested staff be suspended until the investigation was complete for resident safety. The provider did not suspend involved caregivers (Caregiver's G, I, and K) pending the completion of the internal investigation. At approximately 5:30 PM law enforcement arrived at the facility at the request of POA C. The provider paused their internal investigation.

09/24/2024- Resident 1 was taken to his/her previously scheduled primary medical provider appointment. The medical provider sent Resident 1 to be assessed at the emergency department.

09/27/2024 Law Enforcement Investigator (LEI) F is assigned to the case.

10/06/2024 LEI F advised the provider (DA B) that

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the caregivers involved, who have continued to work at the facility since the incident, need to be removed from working in the home until the police investigation is completed. The provider moved the involved caregivers to alternate facilities within the company where they continued to work with vulnerable residents.

Surveyor reviewed the internal investigation documentation which consisted of 1 incident report, and 3 caregiver interviews. The documentation did not contain resident interviews, communication notes, health monitoring directives, a timeline of events, or a summary of the finding and any conclusion. The caregiver interviews did not contain associated dates or times.

Incident report:
Created by team lead a on 9/23/24 at 9:46 AM- "staff came in this morning and received report from NOC shift staff. Staff had reported that [Resident 1] has a black eye and a couple bruises on his/her arm. I went to check on [Resident 1] s/he was sound to [sic] sleep ..." The incident report notes the care team being notified on 9/23/24 at 9:46 AM. The medical provider was left a voice message and POA C was notified via e-mail. The provider did not ensure the medical provider and POA were contacted timely enough to request emergent assessment and treatment for Resident 1. The incident report identifies 7 areas of injury on Resident 1's body, including bruising on the left side of his/her head, 4 bruises on his/her left arm, and scrapes to bilateral knees. The incident report lists in response to the incident Resident 1's vitals were not taken, s/he was not questioned about his/her pain level, there was no indication a nonverbal pain scale was implemented, and s/he was not transferred to the

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N 158	Continued From page 5 hospital or ER for a qualified medical assessment. Caregiver Interview Summaries written by HR J: Caregiver K- "Friday night when I went in at 9:00 PM is when I saw bruising on [Resident 1] ... other staff on said [s/he] was yelling all day. When I went to check [him/her] out at 9:15 PM I could see [his/her] eye was a little darker than the other. It was darkish color but it wasn't over the entire eyelid. I told [Caregiver I] that [Resident 1] had a bruise and [s/he] said [sic]what I never saw that [sic] ... the next day when I got [him/her] up in the morning [s/he] had two red marks on [his/her] upper left arm ... I also noticed the eyebrow got bigger and was above [his/her] eyebrow. It was a rounded eye bruise and the outside corner of [his/her] eye was purple. I have a feeling [s/he] fell and somebody didn't report it ... Friday and Saturday [Resident 1] was a beast trying to get out of [his/her] bed. [His/her] legs were hanging over the bed trying to get out ... last night was the first night [Resident 1] really slept well ... [s/he] was very active this past weekend with trying to get out of [his/her] bed/ chairs ..." Team lead A, "I got [Resident 1] up on Friday and [s/he] did not have any bruises ... [Caregiver K] reported it to [sic] [him/her] Monday. There was nothing documented, no notes or anything. [Caregiver K] stated to me that [s/he] only asked [Caregiver I] about the bruising. I notified [Caregiver K] to notify me right away when this happens ... I had to tell [Caregiver I] that [s/he] needs to document this kind of thing and I told [Caregiver I] that I need to know right away about stuff like this. [MCO E] told me that [POA C] called the police. They showed up on Monday night but since I was already gone they said they would come back on Tuesday."	N 158		

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N 158	Continued From page 6 Caregiver I- " ... [Caregiver K] told [him/her] [sic] on Saturday morning about the bruising ... [Caregiver I] didn't know about [his/her] underarm bruise until today Monday. [Resident 1] did not fall on Friday. [S/he] was very behavioral- [sic] mostly screaming and [his/her] body turned rigid ... screams that way if [s/he] is wet, uncomfortable or sometimes it's just to scream ... hard to tell if [Resident 1] is in pain but [s/he] calmed down and went to sleep ..." Caregiver G- "On the Friday shift [Resident 1] was climbing out of bed. [S/he] was having a behavioral day. We kept catching [him/her] trying to get out of bed. I would check every few minutes because that's how much [s/he] was trying to get out. [S/he] will yell and yell ... [s/he] will listen to you when you are talking to[him/ her] but when you stop talking [s/he] just keeps yelling ... [s/he] has done it before when [s/he] is having a bad day and we have seen behaviors like this before when we catch [him/her] trying to get out. Then [s/he] would laugh so we would just put [him/her] back ... I have never dealt with [him/her] [sic] fight any transfer ... there was one time Friday [/she] had [his/her] legs hanging off the bed so I had to put [his/her] legs up onto the bed and slide [him/her] back up into the bed ... I did more 1 to one with [Resident 1] that day due to behaviors ... There was no bruising on [Resident 1] on Friday when I worked. [Resident 1] should have a better alarm since there aren't always two people to watch [him/her] ..." Caregiver I and K note the resident's multiple injuries and all the caregivers note Resident 1 had increased behaviors including screaming, yelling, and his/her body turning ridged. Despite the changes in condition the caregivers did not	N 158		

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report the changes, document in the resident's record, provide interventions for possible indicators of pain, or seek qualified medical assessment for the resident.

The interview notes at times reference the resident with a lack of respect, referring to Resident 1 as being "a beast" to get out of bed, referring to the resident's behaviors as having to be "dealt" with that s/he will "yell and yell" in reference to the caregivers own beliefs that it is in response to not getting his/her way and " catching" him/her trying to get out of his/her bed.

Additionally, 2 of the caregiver interviews reference concerns regarding Caregiver G:

Caregiver I notes, " ... I do recall that [Caregiver G] was in a very bad mood on Friday [Caregiver G] is overworked not getting any sleep. I didn't see [him/her] do anything to [Resident 1] but wasn't handling the yelling very well. [Sic] Tried to step in to help out ..."

Caregiver K notes, " ... [Caregiver I] is a good worker but I am not sure about [Caregiver G.] [Caregiver G] is off the wall, kind of off ... I don't feel like [s/he] does a good job. When I come in after [him/her] to relieve [him/her] [s/he] tells me everybody was changed about 30 minutes prior and then I see somebody who's completely soaked or soiled and that bothers me. [Caregiver G] was the one who was working with [Resident 1] on Friday ..."

On 10/10/2024 at approximately 10:00 AM, Surveyor interviewed Resident 2 at the facility. Resident 2 stated s/he enjoyed living at the facility but that there were times when s/he was unhappy. Resident 2 stated, "People yell at me

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N 158	Continued From page 8 ...the workers." Resident 2 described Team Lead A and Caregiver G as becoming overly directive and easily frustrated. Resident 2 stated approximately 2 weeks ago when s/he was going to take a shower Caregiver G became angry and yelled at him/her to get in the shower and "get wet!" Resident 2 stated s/he was "scared to tell anyone" about how the residents were treated because s/he would "get in trouble more" with Team Lead A and Caregiver G if s/he did. On 10/11/2024 at 9:01 AM, Surveyor interviewed DA B with HR H joining at approximately 9:25 AM. DA B stated the provider has an internal investigation team that is comprised of 7 of the providers management team. DA B stated of the 7, HR J was directed to conduct caregiver interviews on 09/23/2024 and did so via phone. DA B stated to his/her knowledge no separate investigation or discussion took place regarding the content of the interviews in terms of the disrespectful language and staff reported concerns regarding Caregiver G. DA B confirmed although the provider had the caregiver interviews alleging concerns with Caregiver G, no further investigation was conducted, and Caregiver G was allowed to continue to work with vulnerable residents unsupervised. DA B confirmed no member of the provider's investigation team went out to the facility on 09/23/2024 to observe/ assess the resident or conduct interviews with the other residents living at the facility who are able. DA B stated as of 10/11/2024 the provider had still not conducted interviews with the residents at the home stating it had not been completed because the police directed the provider to stop their own internal investigation until the police investigation could be completed (this statement is contradicted by interview and record review via LEI F on 10/11/2024, see below.)	N 158		

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N 158	Continued From page 9 Surveyor reviewed the Managed Care Organization's (MCO) notes dated 09/23/2024 by MCO E, who is a care manager and does not hold credentials to medically assess residents: "[MCO E] noted that [Resident 1's] left eye is deep red and purple in color, there is an area of yellow above [his/her] left eyebrow, [Resident 1's] left elbow area has a large deep red bruise, majority of this bruise is above the joint, there is a small area below the joint, there is a yellow and circular bruise above [his/her] left armpit on [his/her] shoulder, there is a circular deep red bruise on [his/her] upper arm next to [his/her] left armpit, there are 2 long scratches and one short scratch on [his/her] chest by [his/her] left armpit, there is a dime sized scrape/injury on each of [his/her] knees ... [MCO E] assessed [Resident 1's] bedroom set up and inquired with staff about whether or not [Resident 1] had fallen off [his/her] bed and/or onto objects in the past, [Resident 1] has not. [MCO E] assessment is that the room set up does not align with accidental injury in these areas that could result from any falls of any sort in the room. [MCO E] verified that [Resident 1] receives assistance with all transfers, CBRF staff verifies that staff utilize the equipment to lift [Resident 1] ... [MCO E] contacted [DA B] to verify that staff that were present during the presented potential timeline of injury will not be working with [Resident 1] until investigation has concluded. [DA B] reports that they will not be putting staff on leave of absence or having them not work due to short staffing. [MCO E] clarified that the request and recommendation is that staff do not work with [Resident 1] directly and presented idea to switch those staff out with staff from another home. [DA B] asked how long this is the recommended	N 158		

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action for, [MCO E] provided encouragement that this happen until their internal investigation has concluded as a way to mitigate any potential safety risks to [Resident 1] during that time. [DA B] stated that they do not know when their internal investigation will conclude and, again, stated that they will not be removing and/or switching staff. [MCO E] inquired about whether or not staff schedules could be changed to verify that those staff were not working alone with [Resident 1] during the investigation time, [DA B] stated that [s/he] will attempt this ...

Assessment: [MCO E] assessment is that [Resident 1] should not be left alone with staff that were working during the presented timeline that injury could have occurred ..."

On 10/11/2024 at 9:01 AM, Surveyor interviewed DA B with HR H joining at approximately 9:25 AM. DA B stated on 09/23/2024 the MCO arrived at the facility at proximately 1:00 PM and requested the provider remove the staff involved until the investigation could be completed. DA B stated the provider did not remove the staff as they could not discern which, if any, staff were responsible from their interviews. DA B stated, "No, we did not move or suspend any staff at that point as the initial staff investigations that we did we were not able to pinpoint any one person. To do that, moving an entire house is obviously challenging for staffing ... We did not have any specific staff at that point that could have caused this, which is why we did not transfer or suspend anybody." DA B stated their investigation was not yet completed, but the provider did not have an alternate staffing plan or protections that had been put into place for resident safety. DA B reviewed the codes and acknowledged immediately protecting residents and ensuring

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their safety until an investigation is concluded would require ensuring staff members potentially involved we're not working with vulnerable residents until a final determination could be made. DA B stated to his/her knowledge once the police became involved, on 09/23/2024 at approximately 5:30 PM, that the provider's internal investigation needed to stop as to not interfere with the police investigation. DA B stated the police's instructions to stop the provider's internal investigation was the reason no member of the provider's investigation team went out to the facility to conduct interviews with the residents. The code was reviewed and DA B acknowledged the code does not specify stopping an internal investigation when police are involved as a requirement but that there is a requirement for the provider to conduct a timely investigation. DA B stated to his/her knowledge the law enforcement officer (LEI) F had instructed staff to stop their investigation as to not interfere with the police investigation. DA B could not state who the police made this statement to. DA B stated their internal investigation continued to be open because the police investigation had not concluded. DA B stated on 10/06/2024 LEI F requested the caregivers involved in the open investigation be suspended from working directly with the residents. On 10/06/2024, 17 days after the initial incident occurred, the staff involved were removed from continuing to provide direct unsupervised care for Resident 1. DA B stated the provider suspended the caregivers from working at the facility but continued to allow them to work at other assisted living programs within their company.

Surveyor reviewed a Misconduct Incident Report (MIR) submitted by the provider on 09/24/2024. The MIR did not include information about the

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N 158	Continued From page 12 caregivers that were being investigated for their potential involvement. On 10/11/2024 at approximately 10:45 AM, Surveyor interviewed LEI F. LEI F stated at no time during the police investigation was the provider asked to suspend their own internal investigation. LEI F stated the initial police contact was approximately 5:30 PM on 09/23/2024 and that the provider's claims that police instructed them to stop their own investigation did not make sense, as by the time the police were there the provider had already completed their interviews with the direct caregivers. LEI F stated s/he had a discussion with DA B on 10/02/2024 about reassigning staff. The staff were not reassigned until 10/06/2024. As of 11/04/2024, no additional information or completed investigation documentation has been received. Cross Reference N0431 DHS 83.83(1)(g) Health Monitoring	N 158		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical	N 431		

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N 431	Continued From page 13 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 interview and record review, the provider did not ensure Resident 1 received health monitoring to meet his/her needs. Resident 1 sustained multiple injuries of unknown origin, including a head injury, that required an investigation into potential caregiver misconduct. The injuries were not reported for 3 days after staff observed them. Resident 1, who has limited ability to express him/herself was reported to have increased behaviors during the 3 days after the injuries were observed. There was no documentation of the injuries, no intervention for potential pain management, and the provider waited 5 days before having Resident 1 seen by a qualified medical professional.	N 431		

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N 431	Continued From page 14 Findings Include: On 09/24/2024, the Department received a complaint alleging the provider did not provide health monitoring to meet a resident's need after the resident was found with multiple injuries of unknown source. On 10/10/2023, Surveyor reviewed Resident 1's records and noted Resident 1 was admitted on 08/26/2021 with diagnoses including Down's Syndrome, Atlantoaxial Instability, Obsessive Compulsive Disorder, and other conduct disorders. The Individual Service Plan (ISP) identified the resident as requiring full assistance for activities of daily living including being non-ambulatory, requiring a lift and some assistance to reposition him/herself. The ISP notes: Maturation- "It has been recently reported that there has been a decline and that it appears that [s/he] is not following directions. [She] is nonverbal. [S/he] is not making requests." Pain Management- "The guardian says [s/he] has a high tolerance for pain. [S/he's] not been exhibiting pain ... monitor severity of pain, be pain free." Mental Illness- "[Resident 1] has OCD and oppositional defiance disorder. [She] will moan and groan ... If [s/he] does not get [his/her] way [s/he] will moan and groan, yell out, grit [his/her] teeth. [sic] lifts [his/her] behind up in the chair or bed." Attitude- "[Resident 1] is typically in a good mood. may need staff assistance if [s/he] appears upset. Signs [s/he] is upset is if [s/he] is moaning,	N 431		

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groaning, yelling get it, lifting [his/her] behind out of chairs or bed. [S/he] will also grit and grind [his/her] teeth if unhappy. Staff will attempt to meet [Resident 1's] needs by offering a snack, liquids, [sic] checks for incontinence. If those needs have been met then [Resident 1] may want to lay down in [his/her] bed to watch a movie ..."

The ISP does not address the behavioral symptoms as potential nonverbal pain signals as the resident is limited in ways to express distress and communicate. The ISP does not list any signs or symptoms of how the resident expresses pain, and does not list any nonverbal pain assessment tools or interventions for pain management.

On 10/10/2024 at approximately 9:30 AM, Surveyor interviewed Caregiver L with Caregiver M joining at approximately 9:50 AM. Caregiver L stated Resident 1 can be loud/ disruptive at times but is typically in a good mood and his/her behaviors are manageable. Surveyor asked Caregiver L how Resident 1 expresses him/herself. Caregiver L described Resident 1 as frequently making guttural outburst noises along with limited words. Caregiver L described Resident 1's ability to communicate when s/he is upset by increasing verbal outbursts and at times attempting to lift his/her hips out of his/her wheelchair. Caregiver L stated the behaviors are associated with when Resident 1 is frustrated or upset about something. Surveyor asked Caregiver L how Resident 1 expressed pain. Caregiver L was unable to answer. Caregiver L stated his/her presumption that when Resident 1 had an increase in behaviors it was associated with frustration and being tired rather than any association with potential pain. Surveyor asked Caregiver L if the facility utilized a nonverbal pain

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assessment tool. Caregiver L stated there was a smiley face scale but that s/he was unsure if Resident 1 would be able to adequately comprehend the self-assessment and indicate his/her level of pain using the scale.

On 10/11/2024 at 9:01 AM, Surveyor interviewed Division Administrator (DA) B with Human Resources (HR) H joining at approximately 9:25 AM. DA B discussed the approximate timeline of events:

09/20/2024- Caregiver K noticed bruising on Resident 1's eye upon arrival at approximately 9:00 PM. Caregiver K stated s/he brought it to Caregiver I's attention. No caregivers documented any changes in condition or health monitoring in Resident 1's record. No caregivers notified management or the Resident 's care team. No caregivers sought assessment or treatment for the resident who was presenting with an unwitnessed head injury.

09/21/2024- Caregivers I and K worked. Caregiver K noticed red marks on the residents arms and that the bruising on his/her eye was bigger and swollen. Caregiver I reported s/he had not been informed about the bruising by Caregiver K until 09/21/2024. No caregivers documented any changes in condition or health monitoring in Resident 1's record. No caregivers notified management or the Resident 's care team. No caregivers sought assessment or treatment for the resident who was presenting with a swollen head injury.

09/22/2024- Caregivers I and K worked. No caregivers documented any changes in condition or health monitoring in Resident 1's record. No caregivers notified management or the Resident

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N 431	Continued From page 17 's care team. No caregivers sought assessment or treatment for the resident who was presenting with a swollen head injury. 09/23/2024- Caregiver K reported the bruising to Team Lead A at approximately 6:00 AM. Team Lead A reported the injuries to DA B at 8:45 AM. At 9:46 AM Team Lead A created an incident report and notified POA C and Resident 1's care team. The provider notified Resident 1's MD by leaving a voice message. The provider did not seek assessment or treatment for the resident. The provider did not update the ISP or implement interventions for health monitoring based on the injuries/ change in condition. 09/24/2024 Resident 1 was taken to his/her previously scheduled primary medical provider appointment. The medical provider sent Resident 1 to be assessed at the emergency department. Caregiver Interview Summaries written by HR J: Caregiver K- "Friday night when I went in at 9:00 PM is when I saw bruising on [Resident 1] ... other staff on said [s/he] was yelling all day. When I went to check [him/her] out at 9:15 PM I could see [his/her] eye was a little darker than the other. It was darkish color but it wasn't over the entire eyelid. I told [Caregiver I] that [Resident 1] had a bruise and [s/he] said [sic]what I never saw that [sic] ... the next day when I got [him/her] up in the morning [s/he] had two red marks on [his/her] upper left arm ... I also noticed the eyebrow got bigger and was above [his/her] eyebrow. It was a rounded eye bruise and the outside corner of [his/her] eye was purple ... Friday and Saturday [Resident 1] was a beast trying to get out of [his/her] bed. [His/her] legs were hanging over the bed trying to get out ... last night was the first	N 431		

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night [Resident 1] really slept well ... [s/he] was very active this past weekend with trying to get out of [his/her] bed/ chairs ..."

Team lead A, "I got [Resident 1] up on Friday and [s/he] did not have any bruises ... [Caregiver K] reported it to [sic] [him/her] Monday. There was nothing documented, no notes or anything. [Caregiver K] stated to me that [s/he] only asked [Caregiver I] about the bruising. I notified [Caregiver K] to notify me right away when this happens ... I had to tell [Caregiver I] that [s/he] needs to document this kind of thing and I told [Caregiver I] that I need to know right away about stuff like this ..."

Caregiver I- "... [Caregiver K] told [him/her] [sic] on Saturday morning about the bruising ... [Caregiver I] didn't know about [his/her] underarm bruise until today Monday. [Resident 1] did not fall on Friday. [S/he] was very behavioral- [sic] mostly screaming and [his/her] body turned rigid ... screams that way if [s/he] is wet, uncomfortable or sometimes it's just to scream ... hard to tell if [Resident 1] is in pain but she calmed down and went to sleep ..."

Caregiver G- "On the Friday shift [Resident 1] was climbing out of bed. [S/he] was having a behavioral day. We kept catching [him/her] trying to get out of bed. I would check every few minutes because that's how much [s/he] was trying to get out. [S/he] will yell and yell ... [s/he] will listen to you when you are talking to[him/ her] but when you stop talking [s/he] just keeps yelling ... [s/he] has done it before when [s/he] is having a bad day and we have seen behaviors like this before when we catch [him/her] trying to get out. Then [s/he] would laugh so we would just put [him/her] back ... I have never dealt with [him/her]

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[sic] fight any transfer ... there was one time Friday [/she] had [his/her] legs hanging off the bed so I had to put [his/her] legs up onto the bed and slide [him/her] back up into the bed ... I did more 1 to one with [Resident 1] that day due to behaviors ... There was no bruising on [Resident 1] on Friday when I worked. [Resident 1] should have a better alarm since there aren't always two people to watch [him/her] ..."

Caregiver I and K note the resident's multiple injuries and all the caregivers note Resident 1 had increased behaviors including screaming, yelling, and his/her body turning ridged. Despite the changes in condition, the caregivers did not report the changes, document in the resident's record, provide interventions for possible indicators of pain, or seek qualified medical assessment for the resident. The Medication Administration Record (MAR) noted Resident 1 had as needed Tylenol ordered that was not documented as administered in September of 2024.

Surveyor reviewed the internal investigation documentation which consisted of 1 incident report, and 3 caregiver interviews. The documentation did not contain resident interviews, communication notes, health monitoring directives, a timeline of events, or a summary of the finding and any conclusion. The caregiver interviews did not contain associated dates or times.

Incident report:
Created by team lead a on 9/23/24 at 9:46 AM-
"staff came in this morning and received report from NOC shift staff. Staff had reported that [Resident 1] has a black eye and a couple bruises on his/her arm. I went to check on [Resident 1]

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N 431	Continued From page 20 s/he was sound to [sic] sleep ..." The incident report notes the care team being notified on 9/23/24 at 9:46 AM. The medical provider was left a voice message and POA C was notified via e-mail. The provider did not ensure the medical provider and POA were contacted timely enough to request emergent assessment and treatment for Resident 1. The incident report identifies 7 areas of injury on Resident 1's body, including bruising on the left side of his/her head, 4 bruises on his/her left arm, and scrapes to bilateral knees. The incident report lists in response to the incident Resident 1's vitals were not taken, s/he was not questioned about his/her pain level, there was no indication a nonverbal pain scale was implemented, and s/he was not transferred to the hospital or ER for a qualified medical assessment. On 10/11/2024 at 9:01 AM, Surveyor interviewed Division Administrator (DA) B with Human Resources (HR) H joining at approximately 9:25 AM. DA B reviewed the incident report and could not state why Resident 1's pain was not assessed or why no health monitoring or change in condition plans and interventions were put into place. DA B could not state why Resident 1's as needed pain medication had not been administered. DA B stated s/he knew Resident 1 had a previously scheduled appointment for the following day 9/24/2024 to see his/her primary medical provider. DA B stated the administration was made aware on 09/23/2024 at 8:45 AM of Resident 1's 7 reported injuries including a head injury and could not state why emergent medical treatment was not provided. DA B stated s/he was aware once the resident was brought in to see his/her primary care medical provider the medical provider ordered Resident 1 to be sent to the emergency department for assessment.	N 431		

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N 431	Continued From page 21 Per the hospital discharge notes on 09/24/2024, Resident 1 was found to be positive for a urinary tract infection. Cross Reference N0158 DHS 83.12.(2)(a) Caregiver: Investigating Abuse & Neglect	N 431		