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{N 000}	Initial Comments On 05/21/2025, Surveyor conducted a verification visit, a standard survey, and 2 complaint investigations at Clarity Care Cardinal. Additional information was gathered through 06/09/2025. One complaint was substantiated, and as a result of the survey, 5 deficient practices were identified, including 2 repeat violations. Under statutory provisions, a $200 revisit fee is being assessed for the follow-up licensing visit. Census: 4	{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:	{N 158}		

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

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{N 158}	Continued From page 1 Based on record review and interview, the provider did not ensure all allegations of caregiver misconduct were investigated. The provider was aware of allegations of caregiver misconduct including misconduct related to Resident 1 and Resident 3. The provider did not conduct investigations, or conducted incomplete investigations, allowed the alleged caregiver to continue working, and/or the resident's legal representative had not been notified. This is a repeat deficient practice. See Statement of Deficiency (SOD) XG7Q11, dated 11/04/2024. Findings include: On 11/25/2024, the Department received a complaint alleging physical restraints being used on residents. Resident 1 On 05/21/2025, Surveyor reviewed Resident 1's record 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) dated 01/20/2025 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. Allegations of Abuse and Injury of Unknown Origin On 05/21/2025, Surveyor reviewed Resident 1's MCO communications and visit notes. In a note dated 10/24/2024 written by MCO RN Y regarding a visit that occurred on 10/23/2024, and a note dated 11/11/2024 written by MCO RN Y regarding a visit that occurred on 11/10/2024, both	{N 158}		

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{N 158}	Continued From page 2	{N 158}		

referenced RN Y witnessing Resident 1 being tied to his/her wheelchair with the straps of the Hoyer sling. RN Y documented education was provided to Caregiver L on 10/23/2024 about proper positioning and restraints. RN Y documented contacting his/her supervisor after the visit on 11/10/2024 where s/he witnessed a "more extreme" restraint being used on Resident 1 and was met with some caregiver resistance to remove the restraint by Caregiver V even after education was provided. Additionally, RN Y noted informing Division Administrator B on 11/ 11/ 2024 regarding the witnessed restraints on 11/10/2024. RN Y documented informing Division Administrator B that there was a bruise of unknown origin found on Resident 1's right forearm and that Caregiver V had been resistant to remove the restraints. RN Y documented Division Administrator B's response that it must have been an accident, without indicating any investigation into the reported use of restraints would occur. Division Administrator B noted s/he would follow up regarding the bruise.

On 05/21/2025 at 1:00 PM, Surveyor requested any follow up documentation from Area Director T. As of 06/09/2025, no additional information was received to indicate an investigation was completed into the bruising of unknown origin or witnessed use of restraints.

Surveyor reviewed an e-mail sent by MCO Provider Quality Specialist Z on 11/11/2024 at 1:13 PM to the provider including Division Administrator B, Area Director T, and Administrator S:

"I got a report on [Resident 1]. The care team visited 11/10/2024 and state the following: Member has palm size bruise to right forearm.

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{N 158}	Continued From page 3 Member was tied into chair with Hoyer pad. Loops from top part of Hoyer pad where looped and hooked on arms of wheelchair. The lower loops from the hoyer pad were crossed between member's legs and pulled up over the handles of the wheelchair, looped and hooked on the back of the wheelchair. This was very tight and difficult for RN to release straps. [Former Caregiver V] staff stated this was how everyone does it so [s/he] does not fall out of chair. [Former Caregiver V] new, 11/10/2024 being [his/her] third day. This would be considered a restrictive measure since [Resident 1] is unable to get out of the restraint. Could you please educate all staff on this, especially the new employee? If [his/her] statement is true that, "everyone does it" then this is of course concerning. Was this employee trained on restrictive measures prior to working with residents? ... " On 11/11/2024 5:18 PM Division Administrator B responded: "I am checking into the bruise on [his/her] arm, I worked in the home on Sunday when I got [him/her] up I did not notice it ... As for the wheelchair thing, the staff called me ... to ask me what I do with the straps from [his/her] Hoyer sling and I told them I wrap them around the wheel chair handles. I do not warp [sic] [him/her] up in the chair but I did not say that, and they cannot read my mind. This is a newer staff I worked with [him/her] a few days and [s/he] worked with another lead so not sure where this is coming from. I do not believe this to be a restrictive measure, just getting the straps out of the way." The provider was informed of two allegations of potential caregiver misconduct including a bruise	{N 158}		

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{N 158}	Continued From page 4 of unknown origin and the use of restrains by the MCO two different times and did not conduct investigations or report the allegations to the Department. On 06/05/2025 at 9:53 AM, Surveyor interviewed Guardian AA. Guardian AA stated s/he had not been informed by the provider or MCO about the allegations of, or witnessed use of restraints on Resident 1. Guardian AA stated s/he was unaware of any investigations conducted as s/he had not even been informed there had been a concern. Guardian AA stated it is his/her legal right to be informed and stated s/he would have wanted to know about the allegations and would have wanted an investigation completed as was required. Resident 3 On 05/21/2025 at 10:10 AM, Surveyor interviewed House Manager R. House Manager R stated Resident 3 was alert, aware, a good historian, and able to communicate his/her needs. On 05/21/2025, Surveyor reviewed Resident 3's records and noted Resident 3 had an activated Power Of Attorney (POA X,) and was admitted on 03/05/2025 with diagnoses including major depressive disorder with severe psychotic symptoms, anxiety disorder, hallucinations, suicidal ideation, and spastic diplegic cerebral palsy. Per Resident 3's Individual Service Plan (ISP) dated 03/05/2025, Resident 3 required total assistance for capacity for self-care, including needing assistance for all positioning needs, a Hoyer lift for transfers, and an electric wheelchair. Resident 3 was identified as requiring total assist with all toileting tasks including catheter care.	{N 158}		

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{N 158}	Continued From page 5 On 05/21/2025 Surveyor reviewed Caregiver P's employee file and noted Caregiver P was re-hired on 09/28/2022 and regularly worked alone on PM to overnight shifts at the facility. On 05/21/2025 at 10:15 AM, Surveyor interviewed Resident 3. Resident 3 stated his/her concerns related to Caregiver P: Allegations of Neglect/ Medication Resident 3 stated Caregiver P neglected to give his/her 10:00 PM dose of "very important" medication (Quetiapine Fumarate; anti-psychotic; Per review of the Medication Administration Record (MAR) on 05/21/2025) "a few" times recently (missed doses noted in the MAR on 05/21/2025 for dates 05/10, 05/11/, 05/12, and 05/15/2025 10:00 PM doses.) Resident 3 stated Caregiver P told him/her that s/he works night shift and "doesn't deal with medications" despite being trained to give medication (per interview with House Manager R on 05/21/2025) and being aware the resident needed the prescribed medication. Resident 3 described the missed doses as not being made in error but intentionally by Caregiver P choosing not to give them. Resident 3 stated s/he had reported this to House Manager R but could not recall the specific dates. On 05/21/2025 at 10:30 AM, Surveyor interviewed House Manager R. House Manager R stated there had been a few times when s/he found Caregiver P had not given Resident 3 his/her 10:00 PM medications and although s/he did not create an incident report for each event s/he noted the missed doses in the MAR and reported to Area Director T the allegation that the medications had willfully not been given by Caregiver P.	{N 158}		

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{N 158}	Continued From page 6 Surveyor corroborated the allegation by reviewing an incident report created by House Manager R (dated 05/16/2025) regarding 1 of the incidents when Caregiver P did not give the medication, reviewing the MAR, and during an interview on 05/28/2025 at 10:41 AM with Area Director T. Regarding the missed doses of Quetiapine Fumarate, Area Director T stated Caregiver P was a trained medication passer and was responsible for administering the doses. Area Director T stated s/he was aware there was a report being made by House Manager R for disciplinary action in response to Caregiver P not giving scheduled medication as House Manager R had previously reported the allegations to Former Division Administrator B and Area Director T. On 05/21/2025 at 1:00 PM Surveyor interviewed Area Director T, Area Director T stated House Manager R had previously reported to him/her (date unknown) that Caregiver P missed giving Resident 3 his/her mediations and that House Manager R planned on writing up a summary for disciplinary action however verified each incident of medication not being given and the Resident's account that Caregiver P was willfully neglecting to give the medication was not investigated or reported to the Department by the provider. On 06/05/2025 Surveyor interviewed POA X. POA X stated s/he had not been made aware by the provider that there had been doses of medication that were not administered or an allegation that the medication may have been intentionally not given. POA X stated had s/he been informed, "I would have been there right away." POA X stated Resident 3 had a history of anxiety and refusing some medications but not his/her Quetiapine Fumarate. POA X stated if s/he did not get his/her	{N 158}		

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scheduled anti-psychotic medication it would increase the likelihood that s/he would refuse his/her other medications including clonazepam, causing greater medication noncompliance and potentially leading to behaviors.

Allegations of Abuse and Neglect / Verbal and Physical
Resident 3 stated s/he and Caregiver P did not "get along" and because of this and Resident 3's inability to physically get away from Caregiver P, Caregiver P would target Resident 3. Resident 3 stated as soon as Caregiver P was the only caregiver present Caregiver P would "get up in my face and yell at me, really close to my face." Resident 3 stated s/he didn't know what to do because s/he physically could not back away from Caregiver P so s/he responded to the caregiver's yelling. Resident 3 stated Caregiver P called him/ her an explicative name and made the resident scared and upset. Resident 3 stated Caregiver P would take away his/her call light as punishment. Resident 3 stated s/he reported the incidents to House Manager R multiple times but could not recall specific dates. Resident 3 stated after a few times of reporting Caregiver P's behavior to House Manager R, House Manager R didn't seem to be "getting anywhere" when s/he reported it to his/her supervisor (Former Division Administrator B.) Resident 3 stated House Manager R was concerned about Resident 3 and gave him/her his/her phone number to call if Caregiver P began to yell at him/her again. Resident 3 stated the same evening (unable to recall specifically when but stated within the "past few weeks") Caregiver P again yelled at the resident. When Resident 3 told Caregiver P s/he was going to call House Manager R, Resident 3 stated Caregiver P took away his/her call button and phone for the night. Resident 3 stated

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{N 158}	Continued From page 8 Caregiver P has taken away his/her call light and phone a few times. On 05/21/2025 at 10:30 AM, House Manager R corroborated Resident 3's statements and stated, "I really care about these residents. Yes, I gave [Resident 3] my phone number. [Resident 3] told me about what has been happening with [Caregiver P.]" House Manager R stated when s/he addressed concerns with Caregiver P, Caregiver P would retaliate by saying s/he would no longer pick up hours on the schedule if management "looked in to [him/her.]" House Manager R could not give specific dates but stated, "I told [Former District Administrator B] and nothing was done. I told [Administrative Assistant Q] and I told [Area Director T] last week. No one cares and nothing is being done about it because we are short staffed and [Caregiver P] always picks up hours." House Manager R stated s/he had additionally reported to Division Administrator B and Area Director T that Caregiver P was found to not be completing cares for Resident 3, including not emptying his/her catheter. Caregiver P stated Area Director T was aware s/he was writing up a summary, including photos, for disciplinary action against Caregiver P related to not completing cares. On 05/21/2025 at 1:00 PM Surveyor interviewed Area Director T. Area Director T stated s/he had been made aware by House Manager R that Caregiver P had been found not completing resident cares but did not conduct an investigation into potential neglect. Area Director T stated House Manager R reported to him/her on 05/20/2025 that Caregiver P had been taking Resident 3's remote and call button away from him/her at night. Area Director T confirmed this would be a form of neglect and abuse of the	{N 158}		

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resident. Area Director T stated s/he had made calls to Human Resources and Caregiver P on 05/20/2025 after hearing about the allegations but had not yet concluded an investigation. Area Director T confirmed, despite being aware of the allegations, beginning an investigation, and understanding the provider's responsibility to first protect the residents, Caregiver P was allowed to continue to work the overnight shift on 05/20/2025 to 05/21/2025.

On 06/05/2025 Surveyor interviewed POA X. POA X stated s/he had not been made aware by the provider of allegations of abuse or neglect towards Resident 3. POA X stated Resident 3 had a significant history of urinary tract infections that require hospitalization and have caused extreme effects for the resident such as becoming nonverbal for "a month." POA X stated with regular care the resident is still susceptible to urinary tract infections and therefore knowingly not providing care for his/her catheter creates significant risk to the resident's health.

POA X stated s/he had been informed that there had been a disagreement between the resident and Caregiver P, however had not been informed about the extent of the concern, that the caregiver had been yelling in the resident's face or that his/her phone had been taken away. POA X stated had s/he been told the full extent of the concerns s/he would have immediately been at the facility addressing the issues with staff. POA X stated s/he was sent an e-mail from Area Director T but that the correspondence was not inclusive of the extent of the allegations:

On 05/22/2025 9:37 PM, Area Director T wrote to POA X, "Good evening, I wanted to let you know that [Resident 3] reported to staff on Tuesday

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morning that a staff member took [his/her] remote and call light from [him/her] and gave it back to [him/her] in the morning. I went and talked to [him/her] on Wednesday and [Resident 3] told me the same thing along with adding that [s/he] called the staff [explicative] and staff called [him/her] [explicative.] These incidents were reported to our HR Department and the staff was pulled from all hours and we are doing an internal investigation on this. I have also filed a self-report with DHS on this incident as well."

The provider did not include they had initially been made aware of the concern on 05/20/2025 and allowed the caregiver to continue to work that evening or that during the survey process on 05/21/2025 Resident 3 alleged his/her phone had also been taken away and allegations that Caregiver P had yelled in Resident 3's face. The communication does not include the additional allegations of not receiving critical medication and cares by the same caregiver. Additionally, as of 06/09/2025 the Department has not received a self-report from the provider.

Despite having a write up for Caregiver P's employee file, the provider did not conduct investigations. There was no timeline beginning when the concerns were first discovered or allegations were first made to the provider, there were no interviews conducted with the residents or staff members involved, there was no documentation of steps taken in an investigation or of findings, there was no reporting to the resident's legally responsible party, or to the Department.

Allegations of Drugs and Alcohol Use
On 05/21/2025 at 1:00 PM Surveyor interviewed Area Director T. Area Director T stated s/he had

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been made aware on 05/07/2025 that an open container of alcohol was found in the facility refrigerator after Caregiver P worked the night shift. Area Director T stated s/he believed House Manager R may have confronted Caregiver P about it but did not know when and stated to his/her knowledge no investigation was conducted, as it would be difficult to prove it was Caregiver P's alcohol. Caregiver P had not been sent by the provider to be tested for the presence of alcohol upon its discovery.

Surveyor reviewed correspondence between House Manager R and Area Director T:

05/07/2025 7:23 PM House Manager R sent Area Director T photos 3 and 4.

05/08/2025 at 3:26 PM Area Director T sent to House Manager B, "Were you able to talk to the two staff that worked the night before regarding what you found in the fridge?"

House Manager R responded at 6:56 PM, "I was not able to talk to them since [Caregiver U] called in today and [Caregiver P] is out of state ..."

Area Director T responded at 6:59 PM, "No worries. Just wanted to see if you talked with either of them..."

There was no further documentation regarding the incident.

During the interview with Area Director T on 05/21/2025 at 1:00 PM, Area Director T did not disclose s/he had also been aware of illegal substance packaging found at the facility after Caregiver P worked. (Photos 5, 6, and 7.) Upon review of correspondence between Area Director

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{N 158}	Continued From page 12 T and House Manager R Surveyor discovery additional allegations: 05/11/2025 at 8:21 AM, House Manager R wrote to Area Director T, "Did call [him/her] [sic] talk to [him/her] about it. [S/he] said [s/he] found it outside by [his/her] car and brought it in to put in the trash. This staff told [him/her] that I would throw it out. [S/he] questioned the staff about what portable table and where it was. [S/he] did say [s/he] was sitting in that area last night. I was here till [sic] about 8:11 PM or so. That was not outside by the driveway or inside the home." At 5:33 PM, House Manager R wrote back to Area Director T asking if s/he has seen the pictures that were sent earlier. The pictures were recent at 5:37 PM. (Photos 5, 6, and 7.) Area Director T responded at 5:41 PM, "Just got them. Did [s/he] appear to be under the influence at all?" House Manager R responded at 5:46 PM, "[S/he] avoided coming close to me today and left quickly. I did call [him/her] and ask about the wrapper. Did you see the earlier messages? I sent the first message at 8:21 AM and the 2nd at 9:05 AM. Area Director T responded at 5:52 PM, "Yes I'm getting all my messages and voicemails now that I'm back in town lol. Since we cannot prove [s/he] did not find them in the driveway we are going to have to do the pop-ins line [sic] HR suggested and keep a very close eye on [him/her.] Any suspicions that [s/he] is under the influence will require s/he be brought in for testing." House Manager R responded at 5:59 PM, "I know that but [his/her] excuses are ridiculous. [S/he] told me if I start checking up on [him/her] that [s/he] would not pick up hours he re anymore and s/he told me that it would be a	{N 158}		

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{N 158}	Continued From page 13 waste of time for me ..." At 6:03 PM Area Director T responded, "I will talk with HR again tomorrow and update them keep you posted on what they say. Yes [his/her] excuses are ridiculous and has defiantly [sic] cause red flags. I am hoping that doing a pop-in will let [him/her] know how serious we are about these things ..." There was no further documentation regarding the incident. Caregiver P had not been sent by the provider to be tested for the presence of illegal substances upon the discovery of an open wrapper of illegal substance in the facility after his/her shift. The provider did not conduct an investigation into the allegation that the caregiver was using illegal drugs while at work and did not report the incident to local authorities or the Department. On 05/28/2025 at 10:41 AM, Surveyor interviewed Area Director T. Area Director T stated to his/her knowledge no investigations into the allegations of drug and alcohol use were completed. Area Director T stated s/he would look to see if there was any other documentation and send it to Surveyor. As of 06/09/2025 no additional documentation has been received. Cross Reference N0351 DHS 83.32(3)(g) Rights of Residents: Physical Restraints N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0431 DHS 83.83(1)(g) Health Monitoring	{N 158}		
N 351	83.32(3)(g) Rights of Residents: Physical restraints In addition to the rights under s. 50.09, Stats.,	N 351		

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N 351	Continued From page 14 each resident shall have all of the following rights: Freedom from physical restraints. Be free from physical restraints except upon prior review and approval by the department upon written authorization from the resident ' s primary physician or advanced practice nurse prescriber as defined in s. N 8.02(2). The department may place conditions on the use of a restraint to protect the health, safety, welfare and rights of the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not insure Resident 1 was free from physical restraints. Resident 1 was found on 11/10/2024 to be restrained by being tied to his/her wheelchair with straps. The provider is licensed to serve up to 5 residents in the facility who may be physically disabled, developmentally disabled, emotionally disturbed/ mental illness, of advanced age, terminally ill, and/ or have irreversible dementia/ Alzheimer's. At the time of the survey, 4 residents resided at the facility. Findings include: On 11/25/2024, the Department received a complaint alleging the provider was utilizing restraints on a resident. On 05/21/2025, Surveyor reviewed Resident 1's record and noted Resident 1 was admitted on 08/26/2021 with diagnoses including Down's Syndrome, Atlantoaxial Instability, Obsessive Compulsive Disorder, and other conduct	N 351		

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disorders. The Individual Service Plan (ISP) dated 01/20/2025 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:

Mental Illness- "[Resident 1] has OCD and oppositional defiance disorder. [S/he] 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, 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..."

Surveyor reviewed Resident 1's Managed Care Organization (MCO) communications and visit notes:

Note dated 10/24/2024, written by MCO RN Y, regarding a visit that occurred on 10/23/2024: "RN noted that hoyer [sic] pad was in place in [his/her] wheelchair. Hoyer pad is a between the leg cross [sic.] In the chair, the long ends that cross were tightly tucked into the sides and the back of the pad where members back would lay was perfect on the back of the chair with the loops tightly wrapped around wheelchair handles. Loops where [sic] so tight RN could not get them off."

Note dated 11/11/2024, written by MCO RN Y, regarding a visit that occurred on 11/10/2024: "Member has palm size bruise to right forearm.

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N 351	Continued From page 16 Member was tied into chair with Hoyer pad. Loops from top part of Hoyer pad where looped and hooked on arms of wheelchair. The lower loops from the Hoyer pad were crossed between member's legs and pulled up over the handles of the wheelchair, looped and hooked on the back of the wheelchair. This was very tight and difficult for RN to release straps. [Former Caregiver V] stated this was how everyone does it so [s/he] does not fall out of chair. [Former Caregiver V] new, 11/10/24 being [his/her] third day. RN asked who did it or who trained [him/her.] [Former Caregiver V] would not answer. RN spoke with [Alternate House Manager W], house supervisor from other building, [Alternate House Manager W] stated [s/he] did not get [Resident 1] up and didn't do it. [Former Caregiver V] said [s/he] helped the other staff het [get] [him/her] up however still would not give a name. [Former Caregiver V] said again that everyone does it. RN asked [Alternate House Manager W] who was there before her, [Alternate House Manager W] stated [Division Administrator B.] RN educated staff on restraints, Hoyer use, fall prevention, care plans, and safety ... RN spoke with [Division Administrator B], Facility Director. RN updated [Division Administrator B] on findings from 11/10/24. [Division Administrator B] stated that [s/he] had told [Former Caregiver V] to loop straps of Hoyer pad on w/c handles so it must have been an accident with tying member in w/c. RN stated [Former Caregiver V], did not want RN to remove straps because member would scoot forward and fall out of chair. [Division Administrator B] stated [s/he] didn't know, doesn't know if [Former Caregiver V] always understands, and that [s/he] thought [s/he] understood that [s/he] meant to keep them out of the way and not to tie [Resident 1] in the w/c. [Division Administrator B] stated that [Former	N 351		

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Caregiver V] does know who [s/he] is and [his/her] name so [s/he] was unsure why [s/he] didn't know yesterday. RN [sic] that [Former Caregiver V] did not know it yesterday and stated that [Division Administrator B] put the Hoyer pad that way. [Division Administrator B] denied doing this and again stated it was on accident. RN again stated that [Former Caregiver V] did not want RN to untie Hoyer pad because member would scoot forward and fall out of chair. [Division Administrator B] stated [s/he] wasn't sure. RN asked about bruise on member's right forearm, [Division Administrator B] wasn't aware but would f/u [sic.]"

This was the 2nd report of the resident's Hoyer sling being tied to his/her wheelchair made by MCO RN Y and did not denote an accidental communication error. The provider was notified on 10/23/2024 during MCO RN Y's facility visit when s/he initially identified the restraint to Caregiver L and again on 11/10/2024.

Surveyor reviewed employee timecards and noted the provider staffed 1 caregiver during the day unless there was a particular reason another staff was needed, such as training. On 11/10/2024 Former Caregiver V was working his/her 3rd day being trained by Division Administrator B and then Alternate House Manager W. Division Administrator B worked from 10:47 AM through 1:05 PM while Former Caregiver V worked 11:12 AM through 8:08 PM and Alternate House Manager worked 1:04 PM through 7:57 PM. If Division Administrator B had not participated in getting Resident 1 up with the trainee, Former Caregiver V on 11/ 10/ 2024, s/he was present at the facility after the resident was up for the day and the restraints were visible. Additionally Alternate House Manager W was

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also present when the MCO discovered the restraint being used.

Surveyor reviewed an e-mail sent by MCO Provider Quality Specialist Z on 11/11/2024 at 1:13 PM to the provider including Division Administrator B, Area Director T and Administrator S:

"I got a report on [Resident 1] The care team visited 11/10/24 and state the following: Member has palm size bruise to right forearm. Member was tied into chair with Hoyer pad. Loops from top part of Hoyer pad where looped and hooked on arms of wheelchair. The lower loops from the hoyer [sic] pad were crossed between member's legs and pulled up over the handles of the wheelchair, looped and hooked on the back of the wheelchair. This was very tight and difficult for RN to release straps. [Former Caregiver V] staff stated this was how everyone does it so [s/he] does not fall out of chair. [Former Caregiver V] new, 11/10/24 being [his/her] third day.

This would be considered a restrictive measure since [Resident 1] is unable to get out of the restraint. Could you please educate all staff on this, especially the new employee? If [his/her] statement is true that, "everyone does it" then this is of course concerning. Was this employee trained on restrictive measures prior to working with residents? ... "

On 11/11/2024 5:18 PM Division Administrator B responded:
"I am checking into the bruise on [his/her] arm, I worked in the home on Sunday when I got [him/her] up I did not notice it ..."

Division Administrator B acknowledged s/he got

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N 351	Continued From page 19 Resident 1 up for the day to his/her chair on 11/10/2024. " ...As for the wheelchair thing, the staff called me right after I left and minutes before [s/he] showed up to the house to ask me what I do with the straps from [his/her] Hoyer sling and I told them I wrap them around the wheel chair handles. I do not warp [sic] [him/her] up in the chair but I did not say that, and they cannot read my mind. This is a newer staff I worked with [him/her] a few days and [s/he] worked with another lead so not sure where this is coming from. I do not believe this to be a restrictive measure, just getting the straps out of the way." On 06/05/2025 at 8:58 AM, Surveyor interviewed Former Caregiver V. Former Caregiver V stated s/he recalled s/he had only been working at the facility for about a week when the Managed Care Organization (MCO) RN Y came to the facility (11/10/2024.) Former Caregiver V confirmed using the straps of the Hoyer sling under Resident 1 while s/he was sitting in his/her wheelchair to crisscross between Resident 1's legs and then hook back onto the handles of the wheelchair. Former Caregiver V stated, "This was the way that everyone did it, all the supervisors ... because [Resident 1] would fall out of [his/her] chair." Former Caregiver V stated this was how s/he was trained to place Resident 1 in his/her chair for safety and s/he had not questioned it. On 06/05/20204 at 10:17 AM, Surveyor interviewed MCO RN Y. MCO RN Y stated after witnessing Resident 1 being tied to the wheelchair on 10/23/2024 s/he reported his/her observations and documented the findings in the record. MCO RN Y stated s/he asked the caregiver present (Caregiver L) about the	N 351		

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N 351	Continued From page 20 restraint and Caregiver L responded s/he had not realized s/he had caused a restraint with the straps. MCO RN Y stated the second time s/he witnessed Resident 1 being restrained on 11/10/2024, "It was more extreme. It was so tight I don't know how they were even able to get the straps that far back to reach the handles. I had to lift [Resident 1's] legs up just to be able to get the straps back off of the handles. I Don't know how they did it ... it was so tight ... unless they really pulled [his/her] legs back hard." MCO RN Y stated it was not by accident as Former Caregiver V did not want to remove the restraint because s/he stated it was keeping the resident in his/her chair. MCO RN Y stated apart from the trainee Alternate House Manager W was present and had permitted the restraint as well. Cross Reference N0158 DHS 83.12.(2)(a) Caregiver: Investigating Abuse & Neglect N0431 DHS 83.83(1)(g) Health Monitoring	N 351		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 3 received all medication prescribed by his/her physician. Resident 3 missed 36 doses of medications, with	N 352		

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N 352	Continued From page 21 32 out of 36 doses missed due to not being available at the facility. Findings Include: 05/21/2025 at 10:10 AM, Surveyor interviewed House Manager R. House Manager R stated Resident 3 was alert, aware, a good historian, and able to communicate his/her needs. On 05/21/2025 at 10:15 AM, Surveyor interviewed Resident 3. Resident 3 stated there were "many" times s/he did not received his/her scheduled medications but could not recall specific dates or which medications. Resident 3 stated apart from the regularly missed doses of different medication, s/he was "upset" specifically because there had recently been "a few" occasions recently when Caregiver P did not give Resident 3 his/her 10:00 PM dose of medication Resident 3 stated were "very important" for him/her not to miss. Resident 3 stated Caregiver P told him/her that s/he works the night shift and "doesn't deal with medications." On 05/21/2025, Surveyor reviewed Resident 3's records and noted Resident 3 had an activated Power Of Attorney (POA X,) and was admitted on 03/05/2025 with diagnoses including diabetes, major depressive disorder with severe psychotic symptoms, anxiety disorder, hallucinations, suicidal ideations, insomnia, and gastroesophageal reflux disease. The resident's prescribed medications for treatment included clonazepam, metformin, sucralfate, melatonin, Linzess, acidophilus, magnesium oxide, and quetiapine fumarate. Surveyor reviewed Resident 3's Medication Administration Record (MAR) for April and May of 2025 and discovered 32 incidents when	N 352		

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prescribed medication was not given to the resident for reasons listed as "Supply Not Present" or "Other: Not available" on 04/10/2025, 04/11/2025, 04/14/2025, 04/15/2025, 04/16/2025, 04/22/2025, 04/23/2025, 04/24/2025, 04/25/2025, 04/26/2025, 04/27/2025, 04/28/2025, 04/29/2025, 04/30/2025, 05/10/2025, 05/11/2025, and 05/19/2025. Surveyor noted the MAR documentation appeared to be inconsistent, as an example, in April the 8:00 AM dose of clonazepam was marked unavailable to be given on 04/11/2025, then was marked as given on 04/12/2025 and 04/13/20205. The medication was then marked as unavailable on 04/14/2025, given on 04/15/2025, and again unavailable on 04/16/2025.

In addition to the 32 doses of medication not received, Surveyor discovered 4 additional missed doses of medication. Quetiapine Fumarate (an antipsychotic medication) documented by House Manager R in the MAR as "Night shift staff did not give to resident ..." on 05/10/2025 and "Not given by night staff" on 05/11/2025. The medication was left blank on 05/12/2025 and 05/15/2025 with no corresponding notation.

On 05/21/2025 at 10:30 AM, Surveyor interviewed House Manager R. House Manager R stated review of the MAR was part of his/her job responsibilities and to his/her knowledge, the MAR accurately reflected when medications were given to the resident and when they were not. House Manager R stated s/he knew some medications had not been "at the house" to give Resident 3. House Manager R stated s/he had filled out an incident report regarding 2 missed doses of medication Caregiver P noted in the MAR as given but s/he had discovered were at

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N 352	Continued From page 23 the facility and had not been given by Caregiver P, and that s/he was aware there had been more incidents when medication was not received (unable to specify when.) On 05/21/20205 at 11:40 AM, Surveyor was sent 2 incident reports (dated 05/15/2025 and 05/16/2025) from Administrative Assistant Q. The incident reports were written by House Manager R and noted the 8:00 PM dose of Clonazepam on 05/14/2025 and the 10 PM dose of quetiapine fumarate on 05/15/2025 had not been given. Surveyor reviewed communication notes between House Manager R and Area Director T dated 05/20/2025: 1:22 PM, House Manager R, "... [Caregiver P] is marking medications on the MAR that are not here. [S/he] is marking them as given. I had [Caregiver U] verify that they are not here ... 3 of [Resident 3's] (Acidophilus capsule, magnesium oxide 400 mg tab, and vitamin C 1000 milligram.)" 1:29 PM, Area Director T, "Are these meds [sic] DC'd [sic] or waiting for refills ect [sic] as to why they are not here? You can add this to [his/her] med [sic] error write up [sic.]" 1:55 PM House Manager R, "... Waiting on Lakeland ... to find out why they denied [Resident 3's] meds [sic.]" On 05/28/2025 at 10:41 AM, Surveyor interviewed Area Director T. Area Director T stated the provider ensures the MAR accurately reflects when the residents receive medication. Regarding the missed doses of quetiapine fumarate, Area Director T stated Caregiver P was	N 352		

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N 352	Continued From page 24 a trained medication passer and was responsible for administering the doses. Area Director T stated s/he was aware there was a report being made by House Manager R for disciplinary action in response to Caregiver P not giving the medication. Regarding the 32 other incidents when medication was listed as not available to be given, Area Director T stated the medications may have been ordered by the physician but not available at the facility to give because the medications may not have been financially covered. Area Director T stated in this event the provider should be reaching out to the ordering physician to see if there are alternative medications that can be prescribed. Area Director T could not state if this process had been done in April or May when the resident was documented as not having the medications available or comment on why the medications appeared to be available and given some days and then not available others interspersed throughout the months. Area Director T stated s/he would look into the concern and get back to Surveyor with his/her findings. As of 06/06/2025 no additional information was received. Cross Reference N0158 DHS 83.12.(2)(a) Caregiver: Investigating Abuse & Neglect	N 352		
{N 431}	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health	{N 431}		

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{N 431}	Continued From page 25 monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure adequate supervision and timely arrangements were made to meet Resident 1's health needs. Resident 1 had a history of frequent falls, a medical condition which in which a fall had the potential to cause significant bodily harm, and did not have a timely assessment for or use of a wheelchair that would meet his/her safety needs. The provider was aware Resident 1 required a medical assessment to measure for a chair to meet his/her safety needs and did not promptly arrange for services. During the time prior to medical assessment, the provider was aware the resident required increased health monitoring, including increased supervision and assessment	{N 431}		

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{N 431}	Continued From page 26	{N 431}		

for additional safety measures that may be implemented with approvals. The provider did not provide the additional health monitoring which resulted in a fall that caused significant injury to Resident 1.

This is a repeat deficient practice. (See Statement of Deficiency (SOD) SOD XG7Q11, dated 11/04/2024.

Findings Include:

On 05/21/2025, Surveyor reviewed Resident 1's record and noted Resident 1 was admitted on 08/26/2021 with a guardian (Guardian AA,) and diagnoses including Down's Syndrome, atlantoaxial instability, Obsessive Compulsive Disorder, other conduct disorders, and orthostatic hypotension. The Individual Service Plan (ISP) dated 01/25/2025 identified the resident as requiring full assistance for activities of daily living including being non-ambulatory, requiring a wheelchair and a lift and some assistance to reposition him/herself when in the wheelchair. The ISP noted Resident 1 required 24-hour supervision, will raise his/her "behind" up from the bed or chair if s/he is upset and needs "staff to check on [him/her] often" as s/he will slide down in bed and in his/her wheelchair." The ISP did not identify Resident 1 as a fall risk with a significant history of falls or note any special precautions related to his/her diagnosis of atlantoaxial instability that would need to be followed in the case event of a fall, such as not moving the resident until trained paramedics are able to assess for neck/spine injury.

On 06/05/2025 at 9:53 AM, Surveyor interviewed Guardian AA. Guardian AA stated Resident 1 had a significant history of falls, including falling from

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{N 431}	Continued From page 27	{N 431}		

his/her wheelchair, as s/he would "squirm" out or down the wheelchair which caused Resident 1 to need increased supervision. Due to his/her diagnosis of Atlantoaxial Instability, which Guardian AA explained could result in serious harm at any given incident of physical injury, Guardian AA expressed great concern that Resident 1 continued to have falls. Guardian AA stated since Resident 1 moved to the facility there had been a marked increase in incidents of falls, many of which resulted in the need for emergency department visits. Guardian AA stated the increased falls coupled with the frailty of the resident's cervical spine caused the guardian to ask the provider to increase monitoring of Resident 1's health by looking into any intervention that may assist, including being assessed for the best type and fit of wheelchair, providing increased supervision, and the potential of looking into restrictive measures, such as a lap belt, for safety. Guardian AA stated s/he had been asking the provider and Managed Care Organization (MCO) for a year to get Resident 1 an assessment for a wheelchair that was appropriate to meet Resident 1's safety needs. Guardian AA stated the provider would give Resident 1 different chairs but always as a temporary chair until they could get a medical/physical assessment to measure and discern what type for chair would be safest for him/her. Guardian AA stated, "I'm not a medical professional, I have great respect for [Provider CC and MCO DD] and I have always assumed they were doing what needs to be done to get [Resident 1] what s/he needs, but this has been going on for almost a year." Guardian AA described a back-and-forth dialog between the provider, the MCO, and the Guardian where there seemed to be continual roadblocks to get Resident 1 the assessment and equipment s/he

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{N 431}	Continued From page 28 needs. Guardian AA stated there delays in getting Resident 1 the assessment and equipment s/he need due to back and forth conversations about payer sources, insurances coverage, which medical providers could be used, appointments scheduled then cancelled after finding out that certain medical provider would not qualify under some specification, and frustration because a plan would be put into place with provider only to find out a new employee was hired who didn't know about the situation and/or the provider had not followed through with the plan by making the necessary calls or submitting the necessary paperwork. Guardian AA stated after months of going back and forth with temporary chairs, Resident 1 had a fall from his/her wheelchair (a temporary chair the provider was aware was not tailored to his/her safety needs as they still had not procured the medical assessments and ordered medical equipment) on 01/27/2025 that caused great injury. (Photos 1 and 2.) Resident 1 was then transferred to a sister facility on 02/28/2025. Guardian AA stated to his/her knowledge the current chair Resident 1 is in (as of 06/05/2025 while residing at a sister facility) still may not be Resident 1's official "new chair." Guardian AA expressed great concern and worry about still not having the issue resolved or managed after asking for increased health monitoring continually for months, all while being aware of the resident's fragile physical state and the increasing incidence of falls. On 06/05/2025 at 10:17 AM, Surveyor interviewed MCO RN Y. RN Y stated Resident 1 had a history of falls, including falls from his/her chair and that the MCO would frequently provide education to the facility caregivers regarding Resident 1's care needs for supervision. RN Y stated it had been observed and communicated	{N 431}		

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that Resident 1 would have decreased incidents of falls when s/he was kept near a caregiver and regularly engaged in activity and/ or near others for social stimulation. RN Y stated there was usually only 1 caregiver at the facility during his/her visits and the caregiver would frequently be involved with caring for other residents out of sight of the common areas of the house which would leave Resident 1 unsupervised in another room.

RN Y stated the MCO had been working with the provider "for months" trying to procure a wheelchair to meet Residents 1's safety needs. RN Y stated they would obtain a chair, just to find out it was not suitable, and then made the determination (11/18/2024, per MCO communication records) Resident 1 needed to be medically/ physically assessed for a chair to meet his/her needs. RN Y stated after an extended period of time to figure out payer sources and which medical provider could assess the resident, s/he thought the provider had submitted the paperwork to the rehabilitation/ physical therapy center and completed an appointment with Resident 1's primary physician (in December of 2024,) when s/he found out (in January 2025) they had not followed through. RN Y stated s/he had primarily communicated with Division Administrator B and that there was a period of time when Division Administrator B stopped responding to his/her inquiries about Resident 1 and the status of where the provider was at in the process of obtaining the assessments and orders to meet his/her needs. RN Y stated once s/he discovered the paperwork had not been completed (after Resident 1 fell on 01/26/2025,) and the Resident was still in the temporary chair, s/he submitted the documentation to get the assessments completed and the resident did

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{N 431}	Continued From page 30 receive a Broda chair s/he recalled some time before or after being moved to a sister facility on 02/28/2025. RN Y stated s/he had been made aware of the fall that occurred on 01/26/2025 and stated s/he was aware the resident required increased supervision, and the caregiver had not been in the room when Resident 1 fell from his/her wheelchair. RN Y stated to his/her knowledge prior to the fall the provider had not increased staffing, had not assessed for or submitted for a waiver for a lap belt (or other assessment determined means of restrictive measures that may be appropriate,) and had not completed the steps to get an assessment for a wheelchair to meet his/her safety needs. On 05/21/2025 at 1:00 PM, Surveyor interviewed Area Director T. Area Director T stated s/he was aware there had been ongoing discussion about Resident 1's needs related to safety, supervision, and his/her wheelchair and stated at the time Division Administrator B was primarily responsible for the oversight of the facility and management of Resident 1's service needs involving the MCO and orders. Area Director T stated Division Administrator B no longer worked for the provider and s/he would retrieve any communications s/he could find related to Resident 1's wheelchair and timeline. On 05/21/2025 at 9:54 PM, Surveyor received and e-mail containing communication from September 2024 through January 2025 between the provider, MCO, and Guardian AA related to Resident 1's health assessment needs. Surveyor reviewed the notes along with incident reports and found communication related to Resident 1's frequent falls and need for a wheelchair spanning September through January:	{N 431}		

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{N 431}	Continued From page 31 -Incident Reports dated 09/23/2024, 10/30/2024, 12/17/2024, and 1/26/2025 documented unwitnessed falls. An e-mail dated 09/25/2024 written by RN BB to Human Resources H, "... Staff stated client slides [him/herself] to the floor and out of bed. I asked if they document this each time it occurs staff's reply was no ..." An e-mail dated 11/13/2024 from Division Administrator B to RN Y, MCO E, and including Area Director T, "[Resident 1's] wheelchair arrived yesterday and we are not going to be able to use this one [s/he] continues to slide out of the chair ..." An e-mail dated 11/18/2024 from MCO E to a Division Administrator B and Guardian AA including RN Y and Area Administrator T, regarding Resident 1's new wheelchair being slippery, "...Was there more conversation about this?" Division Administrator B responded, " ... There was no more conversation of this about this. The back of the chair is very high staff are not able to do stuff so [s/he] will have to be a two person boost with this chair ..." MCO E responded, " ... to best rectify the situation we will need to have occupational therapy come to assess the wheelchair and how resident 1 sits and moves in it Division administrator B ... would ... you be able not [sic] contact [medical provider's] office to update them that there are safety concerns with how resident 1 uses the wheelchair and request an order for occupational therapy to do an assessment? ..."	{N 431}		

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{N 431}	Continued From page 32	{N 431}		

The e-mails go on to include back and forth documentation regarding different providers, financial coverage, appointments to be made, and paperwork to be sent for approvals through December 6th. The next document provided was an Incident report dated 01/26/2025, written by Caregiver U:

"Around 3:15 while I was in the kitchen prepping dinner I heard a loud thump so I rushed into the living room and I seen[sic] [Resident 1] laying face down on the ground. [S/he] didn't show any signs of distress but was bleeding from [his/her] mouth and eye was puff [sic] so I got [him/her] off the ground with a Hoyer and called 911 and then notified my supervisor."

The caregiver, who was not licensed or qualified to perform a medical assessment, moved the resident, who had a diagnosis of atlantoaxial instability, after sustaining a known head injury.

01/27/2025 at 9:04 AM Division Administrator B wrote to RN Y, MCO E, and Area Director T, "[Resident 1] fell out of [his/her] wheelchair chair yesterday afternoon. [S/he] was sent to the emergency room to get checked. [Resident 1] was returned to the house and had a bruise on [his/her] forehead, a black eye, bruise on [his/her] chin and [his/her] mouth was bleeding. This morning the bruise went to [his/her] other eye..." (Photos 1 and 2.)

01/27/2025 at 10:54 AM, Division Administrator B wrote to RN Y, MCO E, Area Director T, Administrator S and Guardian AA, "[MCO E] and I did discuss with [MCO E] [sic] on keeping [Resident 1] safe it is going to be a moment-by-moment situation. [Resident 1] will need to be up for meals at a minimum and staff

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{N 431}	Continued From page 33 we'll need to be up within an arm's reach of [him/her] while [s/he] is up in the wheelchair until we can get this resolved. When [Resident 1] is super wiggly the recliner there is not even a safe option at times because [s/he] scoots down in the chair as well. This will be a moment-by-moment situation." On 01/29/2025 at 7:54 PM MCO E wrote in an e-mail to Division Administrator B including RN Y, " ...Just wanted to follow up to see if [Resident 1] had an appointment scheduled with [his/her] primary also has anyone from Greenfield reached out to you yet? I realize it's only been about 48 hours since they received the documentation they needed ..." Surveyor reviewed the e-mails continue on 1/29/2025 to correspond back and forth about when a primary care appointment will be conducted and who will call the rehabilitation center to get a medical assessment for Resident 1. Per interview with RN Y on 06/05/2025 at 10:17 AM, RN Y stated s/he was unsure when Resident 1 was finally seen for a therapy assessment for a wheelchair, when the Resident was given a Broda chair, or if the Broda chair was Resident 1's "final" chair per the therapy assessment. The provider did not ensure Resident 1's health was monitored by providing timely oversight and implementation of Resident 1' medical needs including increased supervision and wheelchair safety assessment and corresponding medical equipment. The provider was aware the resident had a diagnosis that increased the risk for spinal injury with a fall, was not in a wheelchair that was appropriate to his/her needs, had a significant	{N 431}		

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{N 431}	Continued From page 34 history of falls, and was aware the resident required increase supervision while Resident 1 waited for months for the provider to implement interventions. The provider did not ensure health monitoring follow through until after Resident 1 sustained significant injury in a fall. Cross Reference N0158 DHS 83.12.(2)(a) Caregiver: Investigating Abuse & Neglect	{N 431}		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure care was provided to meet the needs of the residents at all times. Residents did not regularly participate in	Y3244		

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Y3244	Continued From page 35	Y3244		

daily activities, had extended wait times to receive cares, and Resident 3 missed a medical appointment.

The provider is licensed to serve up to 4 residents in the facility who may be physically disabled, developmentally disabled, emotionally disturbed/ mental illness, of advanced age, terminally ill, and/ or have irreversible dementia/ Alzheimer's. At the time of the survey, 4 residents resided at the facility.

Findings include:

05/21/2025 at 10:10 AM, Surveyor interviewed House Manager R. House Manager R stated there were 4 residents residing at the facility and stated at times some of the resident's daily cares could take longer than 30 minutes for him/her to complete. House Manager R stated there was usually one caregiver working except for weekdays between 3:00 PM- 8:00 PM when 2 staff would be scheduled. House Manager R stated despite the schedule, there were not always 2 staff present for 3-8 PM on weekdays. House Manager R stated s/he was the only caregiver present at the time and was waiting for another staff to arrive by 10:20 to take Resident 3 to his/her scheduled medical appointment. House Manager R stated, "We'll see if they show up" and remarked, if no staff was available, Resident 3's medical appointment would have to be canceled.

On 05/21/2025 at 10:15 AM, Surveyor interviewed Resident 3. Resident 3 stated s/he was unaware of an activity calendar and that activities were not offered daily. Resident 3 stated "There's only 1 person here to help" and Resident 3 stated, "I just sit in my chair all the time."

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Y3244	Continued From page 36 Resident 3 stated s/he can watch movies in his/her room but there are not daily activities offered at the facility because there is no one available to do them. Resident 3 stated due to there only being 1 caregiver for the majority of the time, s/he has experienced long wait times before the caregiver could assist him/her with his/her care needs. Resident 3 could not state an exact timeframe but stated sometimes, especially when morning cares are being done, s/he has to wait much longer until the staff is finished with 1 or 2 other resident's cares until they can help him/her. Resident 3 stated at times his/her needs feel urgent, such as needing repositioning in his/her chair due to discomfort or assistance with changing his/her Depends and expressed some distress due to having to wait. At 10:25, while interviewing Resident 3, House Manager R came to the Resident's room and let him/her know that due to no other staff arriving to assist, s/he had to cancel and reschedule Resident 3's medical appointment. Both Resident 3 and House Manager R expressed frustration at not having enough staff to meet the resident's needs. Surveyor continued to interview House Manager R privately. House Manager R stated, "It's just me here all day, the next shift too. I come in and none of the residents have been changed, everything is left for me to do and it takes a long time. Some of their cares take longer than others, there are multiple Hoyer lifts, and they have to wait for me to get finished with 1 or 2 [other residents] until I can get to them. There is 1 staff to do everything here. You just can't get to everything." When interviewed at 12:00 PM, House Manager	Y3244		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y3244	Continued From page 37 R stated s/he didn't have the activity calendar for May but showed Surveyor a copy of the activities for the month of April. Surveyor reviewed the activity calendar listed multiple dates with only food items listed as an activity. Surveyor asked if there were other activities for resident to participate in that may meet their interests. House Manager R gave an example of Resident 2 completing his/her daily therapy exercises as an activity. Surveyor interviewed House Manager R on 05/23/2025 at 10:10 AM. House Manager R stated on occasion the food items listed on the activity calendar, such as making muffins, was an activity, but that the food items were usually listed as an activity of convenience because these were tasks that had to be completed by the caregiver anyway. House Manager R stated there was never enough time with only 1 staff working to have daily activities for the residents as the only caregiver had to provide all resident cares, food preparation, housekeeping, laundry, charting and continual supervision. On 05/21/2025 at 1:00 PM, Surveyor interviewed Administrator S with Area Director T present. Administrator S stated s/he was aware Resident 2's daily therapies did not qualify as a leisure activity to meet the resident's interests and stated it was difficult to provide daily activities as some of the residents attended day programs. Administrator S stated s/he was unaware of the resident's care needs not being met or being delayed and stated s/he believed there were times each day when 2 staff were scheduled to be present. On 05/21/2025 at 3:41 PM, Surveyor was sent the time details for staff from	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017539	A. BUILDING: _____ B. WING _____	R-C 06/09/2025

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Y3244	Continued From page 38 04/20/2025-05/20/2025. Surveyor reviewed the record and noted the majority of days documented only one caregiver present at all times.	Y3244		