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N 000	Initial Comments On 06/18/2025, the bureau of assisted living southern regional office conducted a standard survey and complaint investigation at Capitol Lakes Terraces a CBRF located in Madison, WI. As a result of this survey, 3 violations of DHS Chapter 83 were issued. The complaint was substantiated. One violation was a repeat from statement of deficiency 9YS011 dated 03/01/2023. Census: 32	N 000		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 4 residents reviewed	N 302		

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

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N 302	Continued From page 1 had received screening for tuberculosis (TB) using Centers for Disease Control (CDC) and prevention standards. This is a repeat of statement of deficiency (SOD) 9YSO11 dated 03/01/2023. FINDINGS INCLUDE: On 06/18/2025, Surveyors arrived at facility for a standard survey and complaint investigation. RECORD REVIEW EXAMPLE 1: Resident 1 On 06/18/2025, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 07/25/2023. Resident 1's facility record did not contain documentation of TB laboratory screening. EXAMPLE 2: Resident 2 On 06/18/2025, Surveyor reviewed Resident 2's facility record. Resident 2 was admitted to the facility on 04/30/2025. Resident 2's facility record did not contain documentation of TB laboratory screening. EXAMPLE 3: Resident 3 On 06/18/2025, Surveyor reviewed Resident 3's facility record. Resident 3 was admitted to the facility on 01/27/2025. Resident 3's facility record did not contain documentation of TB laboratory screening. EXAMPLE 4: Resident 4	N 302		

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N 302	Continued From page 2 On 06/18/2025, Surveyor reviewed Resident 4's facility record Resident 4 was admitted to the facility on 10/01/2023. Resident 4's facility record did not contain documentation of TB laboratory screening. INTERVIEW: On 06/18/2025 at 2:30 PM, Surveyors discussed the above concerns with Administrator A and Director B. Administrator A reported facility had completed the (TB) risk assessment questionnaire provided by the state (F-01748). Administrator A reported s/he did not realize per CDC standards residents were to be screened for TB via 2-step tuberculin skin test, QuantiFERON Gold (IGRA) blood test, or chest x-ray (CXR) 90 days before or 7 days after admission to the facility. Administrator A stated s/he would try to have residents obtain these screens as soon as reasonably possible.	N 302		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was free from	N 348		

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physical and abuse.
Resident 1 utilized a power wheelchair for mobility and EZ-stand for transfers. Resident 1 had difficulty with verbal communication and required a communication board for assistance.

On 05/23/2025, Caregiver J observed Previous Caregiver F transfer Resident 1 without an EZ stand, aggressively pull-on Resident 1's arm during repositioning, speak about Resident 1 as if they weren't in the room, and disregard Resident 1's non-verbal signs of pain.

On 06/09/2025, Resident 1 reported Previous Caregiver F had twisted his/her (chest area) and hit his/her [genital area].

On 06/17/2024, Administrator A terminated Previous Caregiver F's employment for not administering care to provider's expectations.

FINDINGS INCLUDE:

On 06/18/2025, Surveyors arrived at facility for a standard survey and complaint investigation.

RECORD REVIEW:

On 06/18/2025, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 07/25/2023. Resident 1 had an activated power of attorney (APOA). Resident 1 had been recently admitted to hospice service. Resident 1 was diagnosed with but not limited to Alzheimer's disease, sleep apnea, gastro-esophageal reflux disease (GERD), and unspecified abnormalities of gait and mobility.

On 06/18/2024, Surveyor received Resident 1's ISP. Resident 1's ISP was not signed or dated.

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Resident 1's ISP documented that s/he required an EZ-stand with 1-staff assistance for transfers. Resident 1's ISP instructed staff to utilize a communication board to help identify his/her needs because his/her speech was disorganized.

On 06/18/2025, surveyor reviewed a document titled, "[Previous Caregiver F] - Employee Misconduct Investigation/Chronology." The document was authored by Administrator A.
1.) On 06/09/2025 at 10:42 AM, Caregiver J sent the following email to Administrator A, "I wanted to bring to your attention on Friday, May 23rd, 2025 I was working on [Name Of Unit] with [Previous Caregiver F]. While I was on shift with [him/her] I witnessed a few things that concerned me. I had already started my med passing at this time, it was roughly around 7:15 PM and I had gotten [Resident 1's] medication ready. When I was reading the med computer I saw that [Resident 1] had a nebulizer that I had never used one before so I asked [Previous Caregiver F] if s/he could show me how to do so ...[Resident 1] was still sitting in [his/her] wheelchair so I turned around and grabbed [Resident 1] sit to stand. I started to wrap [his/her] sling around [him/her] and [Previous Caregiver F] took it from around [him/her] and said "I don't use that" and proceeded to grab [Resident 1] by [his/her] hand and arm stood [him/her] up, placed [Resident 1's] hand on [his/her] bed rail and told [him/her] to move [his/her] feet like [s/he] does with [Physical Therapist L] ... once [Resident 1] sat down on [his/her] bed, [Previous Caregiver F] took [Resident 1's] legs and vigorously swung them into bed. After [Resident 1] was lying in bed, [Previous Caregiver F] grabbed [Resident 1] by [his/her] left arm and aggressively pulled [him/her] up to the top of [his/her] bed. [Previous Caregiver F] then said [s/he'll] do [Resident 1's] medicine. I

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gave [Resident 1] [his/her] pills and eye drops when I was doing [his/her] drops [Previous Caregiver F] had made a comment to me saying "I don't do [his/her] eye drops because [s/he] shuts [his/her] eyes and I don't have time for that", so I continued my administration. [Previous Caregiver F] told me [s/he'd] do [Resident 1's] zinc med and then show me how to do the nebulizer. As [Previous Caregiver F] was unstrapping [Resident 1's] pull tab depends [s/he] got the zinc and placed it on [his/her] fingers and pulled back [genital area] and applied the zinc so hard that Resident 1's catheter tube was visibly moving in and out of place [Resident 1's] face was red and [s/he] was grunting so loud, coughing hard and pushing [Previous Caregivers F's] hand away ..."

2.) On 06/10/2025, Administrator A documented Hospice Nurse G stated Resident 1 reported Previous Caregiver F had hit him/her in the (genital area) and twisted his/her (chest area).

3.) On 06/11/2025 at 5:11 PM, Caregiver C sent the following email to Administrator A, " ...Just wanted to recap on what happened this past weekend ...Around breakfast [Caregiver D] expressed to me that [Resident 1] had told [him/her] [s/he] was afraid of [Previous Caregiver F], and that [Previous Caregiver F] is always very rough with [him/her]. [S/he] then want on to say that [Previous Caregiver F] sometimes "flicks [his/her] [genital area]" ... [Caregiver D] and me were of course very concerned. [His/Her] [spouse] came to visit after that and then the resident expressed [his/her] concerns to [his/her] [spouse] and well, Saying (sic.) [Resident 1] not only did those things but that [s/he] also "twists [his/her] [chest area]" and [s/he] didn't feel safe around [him/her]. We told the resident that we

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would ensure [s/he's] safe here and take care of it by talking to you."

On 06/18/2025, Surveyor reviewed Resident 1's Hospice record. On 06/09/2025 at 8:56 PM, Hospice Nurse G documented the following, " ...There was some bloody drainage on [his/her] compression sleeve. It appears there is a superficially sheared area to [his/her] left elbow ... [Family Member K] closes the door & expressed that it was reported prior that peri-cares were being done "roughly", specifically with application of "cream" to [his/her] [genital area] & that in the past, prior to hospice being involved, that there were reports of that CG (caregiver) 'pushing' pt in the shower. [Family Member K] notes that this was investigated prior and things seemed to "improve." ...Writer did ask pt if [s/he] felt safe at the facility & [s/he] didn't nod or shake [his/her] head. [Family Member K] then asked [Resident 1] to tell RNCM (registered nurse case manager) what happened. [Resident 1] then pointed to [his/her] [chest area] and verbally stated "(caregiver) pinched my [chest area]." ... Writer relayed all the above info to [Administrator A], ... [Administrator A] noted that this particular CG was currently suspended and that an internal investigation would be taking place ..."

INTERVIEWS:

On 06/18/2025 at 11:00 AM, Surveyor discussed allegations of abuse with Caregiver C. Caregiver C reported Resident 1 was cognitively intact and had reported concerns to Caregiver D. Caregiver C reported Resident 1 had difficulty verbalizing his/her needs because his/her words were jumbled and s/he talked in a whisper. Caregiver C reported s/he had worked with him/her for the last couple years and so s/he was someone who

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could understand what Resident 1 was verbalizing when s/he was able to do so. Caregiver C reported that when Caregiver D had questioned Resident 1 s/he very clearly in front of both Caregiver C and Caregiver D. Caregiver C stated Resident 1 reported, "[Previous Caregiver F] hurts me," when asked how s/he reported, "[Previous Caregiver F] flicks his/her [genital area] and s/he is really rough with him/her and twists his/her [chest area]." Caregiver C stated Resident 5 had made complaints about how Previous Caregiver F was providing his/her care to a hospice social worker. Caregiver C reported Previous Caregiver F was then restricted from caring for Resident 5. Caregiver C reported Resident 6 had been heard screaming out during transfers conducted by Previous Caregiver F, and afterwards Previous Caregiver F had been restricted from working on his/her unit.

On 06/18/2025 at 11:20 AM, Surveyor discussed allegations of abuse with Caregiver D. Caregiver D reported that Previous Caregiver F was a hard worker. Caregiver D reported Previous Caregiver F tended to be impatient with residents. Caregiver D reported some residents had made complaints that Previous Caregiver F was rough with cares. Caregiver D reported that s/he had assumed Previous Caregiver F could benefit from increased dementia training. Caregiver D reported s/he had heard Resident 1 verbalize that Previous Caregiver F had twisted his/her (chest area) and hit him/her in the (genital area). Caregiver D stated Resident 1 was not an individual to make up a story like this.

On 06/18/2025 at 11:40 AM, Surveyor interviewed Resident 1 in his/her room. Surveyor initiated interview by asking Resident 1 if s/he could hold Surveyor's hand and squeeze for 'yes'. Resident

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1 partially smiled and held Surveyor's hand. Resident 1 was able to answer 'yes' by squeezing Surveyor's hand and 'no' by not responding, in a purposeful manner. Surveyor could not understand Resident 1's verbalization during the interview. When asked if Previous Caregiver F had showered Resident 1 without permission, Resident 1 did not squeeze Surveyor's hand. When asked if Previous Caregiver F had hurt him/her Resident 1 squeezed Resident 1's hand and gestured towards his/her chest area. Surveyor asked Resident 1 if Previous Caregiver F has hurt him/her in his/her private area. Resident 1 squeezed Surveyor's hand.

On 06/18/2024 at 2:30 PM, Surveyors discussed the above concerns with Administrator A and Director B. Administrator A stated when allegations of abuse were brought to his/her attention. S/he initiated an investigation had suspended Previous Caregiver F from employment. Administrator A reported that after the investigation Previous Caregiver F's employment was terminated. Administrator A reported s/he did not feel she had evidence of physical abuse, but had evidence Previous Caregiver F was not providing care to facilities standards. Administrator A denied abuse allegations from Resident 5 or Resident 6. Administrator A acknowledged during his/her investigation Caregiver J wrote s/he observed Previous Caregiver F grab Resident 1 by his/her left arm and "aggressively pulled" Resident 1 up to the top of the bed, and that Previous Caregiver F did not stop administering Resident 1's zinc cream while, " ...[Resident 1's] face was red, [s/he] was grunting loud, coughing hard and pushing [Previous Caregiver F's] hand away ...". Administrator A acknowledged Resident 1 had been mistreated by Previous Caregiver F and had

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N 348	Continued From page 9 agreed to report Previous Caregiver F to the office of caregiver quality (OCQ).	N 348		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure Resident 1's individualized service plan (ISP) was comprehensive. On 06/18/2025, Surveyor interviewed Resident 1's current ISP. The ISP did not contain documentation of his/her prescribed oxygen therapy via nasal cannula (NC). The ISP did not contain documentation of his/her active right foot wound. The ISP documented Resident 1's indwelling foley catheter, but did not identify methods for catheter care or who was responsible for catheter care.	N 386		

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N 386	Continued From page 10 FINDINGS INCLUDE: On 06/18/2025, Surveyors arrived at facility for a standard survey and complaint investigation. On 06/18/2025 at 11:40 AM, Surveyor discussed Resident 1's daily care tasks with Caregiver D. Caregiver D indicated Resident 1 had an indwelling urinary foley catheter, difficulty with verbal communication and was receiving hospice services. On 06/18/2025 at 11:40 AM, Surveyor interviewed Resident 1 in his/her room. Surveyor observed Resident 1 was fitted with a nasal cannula which was connected to a working oxygen concentrator. Surveyor initiated interview by asking Resident 1 if s/he could hold Surveyor's hand and squeeze for 'yes'. Resident 1 partially smiled and held Surveyor's hand. Resident 1 was able to answer 'yes' by squeezing Surveyor's hand and 'no' by not responding, in a purposeful manner. Surveyor could not understand Resident 1's verbalizations during the interview. On 06/18/2025, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 07/25/2023. Resident 1 was diagnosed with but not limited to Alzheimer's disease, sleep apnea, gastro-esophageal reflux disease (GERD), and unspecified abnormalities of gait and mobility. On 06/18/2025, Surveyor reviewed Resident 1's hospice visit summary dated 06/09/2025. On page 4, the following was documented, "Uses supplemental oxygen: yes ...Pt has loud breathing with exhalation, per family & CGs (caregivers), this is a result of [his/her] disease. This worsens with exertion or when pt is stimulated. Pt wearing	N 386		

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supplemental often t/o (throughout) the day & also at HS (bedtime)." On page 9, Hospice Nurse G documented the following, "Active Wounds ...Wound 03/04/25 1315 (1:15 PM) Pressure Injury Foot Lateral; Right ...Pressure Injury Stage 2."

On 06/18/2024, Surveyor received Resident 1's ISP. Resident 1's ISP was not signed or dated. Under the subsection titled, "Catheter/Ostomy" the following was documented, "Goal Resident's level of assistance with Catheter and/or Ostomy will remain as is or improve through review date ...Interventions Resident Has (sic.) as Foley Catheter ...MAXIMUM Assistance - Staff assists with catheter / ostomy." The ISP did not contain documentation of Resident 1's oxygen therapy or right foot wound.

On 06/18/2025 at 2:30 PM, Surveyor discussed the above concerns with Administrator A and Director B. Administrator A explained s/he had residents and legal representatives sign the annual assessments. Administrator A showed Surveyor Family Member K had signed Resident 1's annual assessment on 02/25/2025. Administrator A acknowledged the ISP had not been signed. Administrator A acknowledged Resident 1's ISP did not contain documentation related to Resident 1's supplemental oxygen therapy or stage 2 pressure injury to the right foot. Administrator A acknowledged Resident 1's ISP did not comprehensively document caregiver's responsibilities related to catheter care.