STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018717	A. BUILDING: _____ B. WING _____	R-C 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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
{N 000}	Initial Comments On 09/09/2024, with information gathered through 10/15/2024, Surveyors conducted 2 verification visits and 3 complaint investigations at The Koselig House. Twenty-five deficiencies were identified. Sixteen of the 25 deficiencies were repeat violations (see Statement of Deficiency (SOD) YSHR11, SOD T56511, and SOD 2U5R12). Three of 3 complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 31	{N 000}		
{N 161}	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 1 occurrences of injuries of unknown origin, fractured ribs, experienced by Resident 4 were investigated. Findings include: On 09/13/2024 at 12:11 PM, Surveyors received an email from Resident 4's Power of Attorney	{N 161}		

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

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{N 161}	Continued From page 1	{N 161}		

(POA) T. POA T stated, " ... [Resident 4] was in [his/her] end-of-life phase at the time. [S/he] died on Wednesday morning. After [his/her] death, it was determined that the coroner needed to do an exam at the facility of the [County] Medical Examiner. Yesterday a scan revealed that my [mother/father] had suffered several rib fractures. I cannot begin to express the anger and grief my entire family feels about this."

On 09/18/2024 at 9:56 AM, Surveyor emailed Administrator O requesting clarification into the findings regarding Resident 4's fractured ribs.

On 09/18/2024 at 10:05 AM, Administrator O emailed Surveyor and stated, "This whole situation is absolutely heartbreaking. ... When I spoke with the ME (medical examiner), [s/he] said [s/he] couldn't tell me anything. I guess I don't know what to do on my end. Add this to the injury of unknown origin report or do I do another report?"
Surveyor noted the injury of unknown origin report that Administrator O referenced was in regard to a bruise that had been identified on Resident 4 on 08/30/2024.

On 09/18/2024, at approximately 1:15 PM, Surveyor interviewed hospice Registered Nurse (RN) CC. RN CC stated, "Due to the concerns of the verbal and physical abused allegations, we requested that the coroner do a body scan prior to transport of [Resident 4] from the building. The coroner determined [Resident 4] had 6 fractured ribs." RN CC stated the local police department had been informed of the concern when they arrived to the facility with the coroner.

On 09/23/2024 at 9:00 AM, Surveyor interviewed Interim Administrator EE. Administrator EE

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{N 161}	Continued From page 2	{N 161}		

stated Administrator O had been removed from his/her position on 09/20/2024. Administrator EE stated s/he was in the process of becoming aware of all the concerns that had been identified.

On 10/12/2024, Detective L from the local police department, emailed Surveyor his/her reports regarding Resident 4's injury of unknown origin, which documented:
"On September 13, 2024, ... I was previously notified by the [County] Medical Examiner's (ME) Office, prior imaging of [Resident 4] during a preliminary exam located an acute left rib fracture with other remote rib fractures; therefore, proceeding to an autopsy. ... After the autopsy ... [Coroner NN] advised [Resident 4] had subacute rib fractures to [his/her] right anterior rib(s) 2, 4, 5, and 6 and left posterior rib number 10. [Coroner NN] also advised left posterior rib number 9 was also possibly fractured. ..."
"On September 21, 2024, ...I asked [Caregiver Z] ... stated it eventually it turns green and brown, but you could see how red and tender [Resident 4's] bruise looked ... [s/he] understood this to be fresh bruising ... reiterated the bruise looked brand new."
"On September 24, 2024, ...I spoke with [Caregiver GG]. ... mentioned [Resident 4] must have gotten dropped and no one said anything about it. ... I asked [Caregiver GG] how [Resident 4] would have obtained [his/her] injuries and [Caregiver GG] stated it looks like due to [Resident 4's] knees, [s/he] believed [Resident 4] was dropped or a fall occurred. [Caregiver GG] stated [s/he] was unsure about the bruising. [Caregiver GG] stated multiple times someone in the facility has to know something and something happened with [Resident 4]."
"On September 24, 2024, ... I spoke with [Caregiver K] ... [Caregiver K] stated [s/he] was

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told by [Caregiver OO] and [Caregiver PP] at approximately 1:30 PM that [Resident 4] had bruising. [Caregiver K] stated [s/he] responded to [Resident 4's] location and saw the bruising which [s/he] described as "pretty large." [Caregiver K] stated [s/he] called [Resident Care Manager Y] and [Administrator O] about the bruising and was instructed to document the incident. [Caregiver K] explained [s/he] did not feel [Resident Care Manager Y] or [Administrator O] cared [Resident 4] had bruises. [Caregiver K] stated on [his/her] own accord, decided to call [Hospice] as [hospice Registered Nurse CC] was at the facility with [Resident 4] earlier. ... [Caregiver K] stated when [s/he] first arrived at the facility, an [hospice CNA QQ (certified nursing assistant)] had given [Resident 4] a shower and mentioned to [Caregiver K], [Resident 4] had skin tears on [his/her] elbows. ... [Caregiver K] stated [Resident 4's bruise was spreading fast. [Caregiver K] stated [s/he] remember when [s/he] came into work that morning, [Resident 4] was sitting in [his/her] wheelchair and normally [Resident 4] has [his/her] pendant [Caregiver K] stated on this morning, [Resident 4] was hunched over and sleeping in the wheelchair. [Caregiver K] indicated [s/he] thought it was due to [Resident 4's] declining health, but it now makes sense due to the bruising. [Caregiver K] described [Resident 4] as leaning forward with [his/her] body to one side ..."

"On September 25, 2024, ...I asked [Caregiver FF] to tell me about the bruise which was located on [Resident 4]. ... [Caregiver FF] stated at 6:00 PM on August 30, 2024, [s/he] returned to work and wanted to see the bruise for [him/herself]. [Caregiver FF] stated [s/he] noticed [Resident 4's] right knee was puffy, swollen and bruised. [Caregiver FF] stated the knee also had a cut. ... [Caregiver FF] explained [Resident 4's] bruise

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was from [his/her] upper left shoulder to the middle of [his/her] chest and was 'huge.' [Caregiver FF] described the bruise as 'bright red.' [Caregiver FF] also explained [Resident 4's elbows were bruised. ... [Caregiver FF] stated the entire staff did not use the Hoyer lift as they should have been and were pivot transferring [Resident 4]. [Caregiver FF] explained the Hoyer lift comes chest level and it looks as if something hit [Resident 4]. From [his/her] prior experience in assisted living facilities, [Caregiver FF] stated [Resident 4's] fall does not make sense with the bruise that was on [Resident 4.]"

On 10/15/2024, Surveyor reviewed Resident 4's hospice documentation which stated:
"08/30/2024 1410 (2:10 PM) [Caregiver K] called writer back to discuss bruise on patient's chest. Writer described bruise to be on the left side of patient's chest, deep red and purple in color. ... [Caregiver K] spoke to other staff members who reported that the bruise was not present yesterday evening, that it must have happened on NOC shift. ..."
"08/30/2024 1534 (2:34 PM) ... Writer asked about new skin tears that were reported by [hospice] this morning. [Caregiver K] was unaware of the skin tears and reports [s/he] feels it is from misuse of transfer devices/lifts, as lots of staff are not sure how to properly use the lifts. ... Patient has redness and purple discoloration/bruising to left side of chest. ... Area is approximately 2.5-3 inches big. ..."
"09/02/2024 - Patients buttocks is red, no open areas. Scattered bruising on left knee cap. 6 x 7.5 inch bruising to left side of chest, up past collarbone. Bruising is purple, yellow and green in color and drastically spread since last assessment."

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{N 161}	Continued From page 5 Cross Reference: N0165 DHS 83.12(4)(c) Reporting Incidents With Serious Injury Cross Reference: N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan	{N 161}		
{N 165}	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the Department within 3 working days when 2 of 2 residents sustained an injury of unknown origin. Resident 4 sustained multiple rib fractures prior to his/her passing which was not reported to the Department. Resident 11 sustained a fracture of the right hip which was not reported to the Department. Findings include: Example 1: Resident 4 On 09/13/2024 at 12:11 PM, Surveyors received an email from Resident 4's Power of Attorney (POA) T. POA T stated, " ... [Resident 4] was in [his/her] end-of-life phase at the time. [S/he] died on Wednesday morning. After [his/her] death, it was determined that the coroner needed to do an exam at the facility of the [County] Medical	{N 165}		

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Examiner. Yesterday a scan revealed that my [mother/father] had suffered several rib fractures. I cannot begin to express the anger and grief my entire family feels about this."

On 09/18/2024 at 9:56 AM, Surveyor emailed Administrator O requesting clarification into the findings regarding Resident 4's fractured ribs.

On 09/18/2024 at 10:05 AM, Administrator O emailed Surveyor and stated, "This whole situation is absolutely heartbreaking. ... When I spoke with the ME (medical examiner), [s/he] said [s/he] couldn't tell me anything. I guess I don't know what to do on my end. Add this to the injury of unknown origin report or do I do another report?"
Surveyor noted the injury of unknown origin report that Administrator O referenced was in regards to a bruise that had been identified on Resident 4 on 08/30/2024.

On 09/18/2024, at approximately 1:15 PM, Surveyor interviewed hospice Registered Nurse (RN) CC. RN CC stated, "Due to the concerns of the verbal and physical abused allegations, we requested that the coroner do a body scan prior to transport of [Resident 4] from the building. The coroner determined [Resident 4] had 6 fractured ribs." RN CC stated the local police department had been informed of the concern when they arrived to the facility with the coroner.

On 10/12/2024, Detective L from the local police department, emailed Surveyor his/her reports regarding Resident 4's injury of unknown origin, which documented:
"I was previously notified by the [County] Medical Examiner's (ME) Office, prior imaging of [Resident 4] during a preliminary exam located an

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{N 165}	Continued From page 7	{N 165}		

acute left rib fracture with other remote rib fractures; therefore, proceeding to an autopsy. ... After the autopsy ... [Coroner NN] advised [Resident 4] had subacute rib fractures to [his/her] right anterior rib(s) 2, 4, 5, and 6 and left posterior rib number 10. [Coroner NN] also advised left posterior rib number 9 was also possibly fractured. ..."

On 10/12/2024, Surveyor reviewed the Department file and noted that no written reports had been submitted to the Department regarding Resident 4's rib fractures.

Example 2: Resident 11

On 09/09/2024, at approximately 9:30 AM, Surveyor interviewed Resident Care Manager (RCM) Y. RCM Y stated that Resident 11 had been hospitalized due to a fall and had not returned to the facility, yet.

On 09/10/2024, Surveyor reviewed Resident 11's record.

Resident 11 moved into the facility, 06/22/2022.

Resident 11's "Observations," dated 07/01/2024 to 09/09/2024, documented:
"08/17/2024 - Incident: Went into room to deliver room tray and found resident lying on the floor in front of wheelchair. Transferred to hospital."

On 09/09/2024, at approximately 1:00 PM, Surveyor interviewed Administrator O. Surveyor stated Resident 11's Incident Report stated s/he had sustained a fall and was hospitalized due to pain.

On 09/18/2024 at 9:25 AM, Surveyor emailed

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{N 165}	Continued From page 8 Administrator O and inquired if s/he had submitted a written report into the Department regrading Resident 11's fall that resulted in hospitalization. On 09/18/2024 at 9:39 AM, Administrator O emailed Surveyor and stated, "My understanding was that [s/he] did not have any injury related to the fall, [s/he] had a health issue which caused the fall so I don't know why we would need to report that. From my understanding of the regulations, we are to report if a serious injury occurred as a result of an incident or accident." On 09/19/2024, Surveyor requested Resident 11's hospital documentation. On 10/15/2024, Surveyor reviewed Resident 11's hospital documentation which stated: 08/18/2024 - X-ray Hip Unilateral - Prior pelvic and right hip radiographs, most recently 08/17/2024. Status post right hip cephalomedullary (surgical procedure) nail placement for a right intertrochanteric hip fracture (break in the upper part of the thigh bone, or femur, between the greater and lesser trochanters). There is improvement in fracture fragment alignment relative to the preoperative radiographs. Cross Reference: N0161 DHS 83.12 (3)(a) Investigate Injuries of Unknown Source Cross Reference: N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment	{N 165}		
{N 196}	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its	{N 196}		

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operation comply with all laws governing the CBRF.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the provider complied with all laws governing the CBRF (community-based residential facility).

This is a repeat deficiency. See Statement of Deficiency (SOD) YSHR11, dated 06/06/2024.

Findings include:

The provider received a regular license on 10/01/2022, as a class CNA (nonambulatory) CBRF able to serve up to 40 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, terminally ill, and physically disabled.

On 09/09/2024, with information gathered through 10/15/2024, Surveyors conducted 2 verification visits and 3 complaint investigations at The Koselig House. Twenty-five deficiencies were identified.

N0161 DHS 83.12 (3)(a) Investigate Injuries of Unknown Source. This is a repeat deficiency. See SOD YSHR11, dated 06/06/2024.
N0165 DHS 83.12(4)(c) Reporting Incidents With Serious Injury
This is a repeat deficiency. See SOD YSHR11, dated 06/06/2024.
N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws. This is a repeat deficiency. See SOD YSHR11, dated 06/06/2024.
N0205 DHS 83.14(2)(j) Not Permit A Condition Of

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Substantial Risk. This is a repeat deficiency. See SOD YSHR11, dated 06/06/2024.
N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operations
N0247 DHS 83.22(1)-(4) Task Specific TrainingN0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment
N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment
N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication. This is a repeat deficiency. See SOD T56511, dated 04/02/2024.
N0383 DHS 83.35(1)(c) Listed Areas For Assessments. This is a repeat deficiency. See SOD T56511, dated 04/02/2024.
N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved. This is a repeat deficiency. See SOD GRGR11, dated 06/02/2022.
N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan. This is a repeat deficiency. See SOD GNOK11, dated 02/17/2022, and SOD T56511, dated 04/02/2024.
N0389 DHS 83.35(3)(d) Service Plans Updated Annually or On Changes. This is a repeat deficiency. See SOD GRGR11, dated 06/02/2022, and SOD YSHR11, dated 06/06/2024.
N0406 DHS 83.37(1)(g) Disposition of Medications
N0408 DHS 83.37(1)(i) PRN Psychotropic Medication. This is a repeat deficiency. See SOD T56511, dated 04/02/2024.
N0415 DHS 83.37(2)(d) Documentation of Medication Administration. This is a repeat deficiency. See SOD T56511, dated 04/02/2024.
N0416 DHS 83.37(2)(e) Other Administration Given Or Delegated by RN
N0425 DHS 83.38(1)(a) Personal Care. This is a repeat deficiency. See SOD T56511, dated

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04/02/2024.
N0431 DHS 83.38(1)(g) Health Monitoring. This is a repeat deficiency. See SOD YSHR11, dated 06/06/2024.
N0448 DHS 83.41(2)(a) Nutrition: Diet
N0450 DHS 83.41(2)(c) Nutrition: Menus
N0452 DHS 83.41(3)(b) Food Safety
N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable. This is a repeat deficiency. See Statement of Deficiency (SOD) 2U5R12, dated 06/01/2023, and T56511, dated 04/02/2024.
N0489 83.44(2)(a) Rooms Clean and Free From Odors. This is a repeat deficiency. See Statement of Deficiency (SOD) GNOK12, dated 07/20/2022.
Y3234 50.09(1)(e) Treatment
Z0010 1-50.065(2)(bb) Determine Final Disposition of Charge. This is a repeat deficiency. See Statement of Deficiency (SOD) GRGR11, dated 06/02/2022.

Review of facility records documented three previous survey events identifying noncompliance, as follows:

SOD YSHR11 - dated 06/06/2024
On 05/21/2024, with information gathered through 06/06/2024, Surveyors conducted 3 complaint investigations. As a result of the survey, nine deficiencies were identified:

N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect
N0161 DHS 83.12 (3)(a) Investigate Injuries of Unknown Source
N0165 DHS 83.12(4)(c) Reporting Incidents With Serious Injury
N0170 DHS 83.12(5)(b) Notification: Abuse and Neglect Allegations

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	0018717	A. BUILDING: _____ B. WING _____	R-C 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSELIG HOUSE (THE)	4897 INNOVATION DRIVE DE FOREST, WI 53532

(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
{N 196}	Continued From page 12	{N 196}		

N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws
N0205 DHS 83.14(2)(j) Not Permit A Condition Of Substantial Risk
N0216 DHS 83.15(3)(c) Qualified Staff Designated As In Charge
N0389 DHS 83.35(3)(d) Service Plans Updated Annually or On Changes. This is a repeat deficiency. See SOD GRGR11, dated 06/02/2022.
N0431 DHS 83.38(1)(g) Health Monitoring

ORDER NOT TO ADMIT NEW OR ADDITIONAL RESIDENTS
Based on the results of the Department's investigation, and pursuant to Wis. Stat. §50.03(5g)(b)7., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that The Koselig House NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations in Statement of Deficiency YSHR11 are corrected, compliance is verified by the Department, and this Order is rescinded in writing.

SPECIAL ORDERS
Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Koselig House:
1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., the licensee shall develop and implement corrective measures to ensure all residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected.
WITHIN 45 DAYS of receipt of this notice, the licensee shall provide training to all managers,

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and resident care staff on the corrective actions taken to resolve each deficiency identified in Statement of Deficiency YSHR11. Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content.
2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., WITHIN 14 DAYS of receipt of this notice, the licensee shall provide the legal representative and the case manager (if any) for each resident with a copy of Statement of Deficiency YSHR11 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from the legal representative and case manager. Required evidence will be made available to the department representatives upon request.

SOD GNOK11 - dated 02/17/2022
On 02/17/2022, Surveyor conducted a complaint investigation at The Koselig House. One deficiency was identified. One complaint was substantiated.

N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan

SOD GRGR11 - dated 06/02/2022
On 05/26/2022, Surveyor conducted a standard survey at The Koselig House. Five deficiencies were identified.
N0310 DHS 83.29(2) Admission Agreement Include Services, Charges
N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved
N0389 DHS 83.35(3)(d) Service Plans Updated

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{N 196}	Continued From page 14 Annually Or On Changes N0393 DHS 83.35(5)(a) Initial Evaluation of Evacuation Limitations Z0010 DHS 50.065(2)(bb) Determine Final Disposition of Charges SOD GNOK12 - dated 07/20/2022 On 07/20/2022, with information gathered through 08/05/2022, Surveyor conducted a verification visit and complaint investigation at The Koselig House. One deficiency was identified. Once complaint was substantiated. N0489 DHS 83.44(2)(a) Rooms Clean And Free From Odors SOD PXZ011 - dated 10/27/2022 On 10/27/2022, Surveyor conducted a complaint investigation at The Koselig House. One deficiency was identified. The complaint was substantiated. N0200 DHS 83.14(2)(e) Notify Within 7 Days Of Administrator Change SOD 2U5R11 - dated 02/01/2023 On 01/30/2023, Surveyor conducted 2 complaint investigations at The Koselig House. Two deficiencies were identified. Two of 2 complaints were substantiated. N0353 DHS 83.32(3)(i) Rights of Residents: Adequate Treatment N0362 DHS 83.33(1)(d) Grievance Procedure: Written Summary N0381 DHS 83.35(1)(a) Pre-Admission and Ongoing Assessments SPECIAL ORDERS: Pursuant to Wis. Stat. §§ 50.03(5g)(b)3. and (b)6., EFFECTIVE	{N 196}		

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{N 196}	Continued From page 15 IMMEDIATELY, the licensee shall comply with requirements specified by Wis. Admin. Code § DHS 83.32(3)(i). That is, the licensee shall provide prompt and adequate treatment appropriate to the needs of the residents. The licensee shall develop and implement corrective measures to resolve each deficiency identified in Statement of Deficiency (SOD) 2U5R11. The licensee's corrective measures, at a minimum, shall include the development (or review) of written procedures to address: Pre-Admission and Ongoing Assessments - The provider shall assess each resident's needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities, or condition, and at least annually. - The assessment, at a minimum, shall include all areas applicable to the resident in accordance with Wis. Admin. Code § DHS 83.35(1)(c). - The provider shall prepare a written report of the results of the assessment and shall retain the assessment in the resident's record. - All managers and resident care staff (as appropriate) will receive in-service training regarding the facility's written procedures required by Order #1. - Training will be documented in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. - A copy of the written procedures required in Order #1 will be made available to department representatives upon request. SOD 2U5412 - dated 06/01/2023 On 06/01/2023, Surveyor completed a verification visit and complaint investigation at The Koselig House. Six deficiencies were identified. The complaint was substantiated.	{N 196}		

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{N 196}	Continued From page 16 N0381 DHS 83.35(1)(a) Pre-Admission and Ongoing Assessments. This is a repeat deficiency. See SOD 2U5411, dated 02/01/2023. N0409 DHS 83.37(1)(j) Proof-of-Use Record N0425 DHS 83.38(1)(a) Personal Care N0441 DHS 83.39(3) Hand Washing N0481 DHS 83.43(1) Environment Safe, Clean, and Comfortable N0487 DHS 83.44(1)(b) Separate Laundry Storage Areas or Containers SOD T56511 - dated 04/02/2024 On 03/13/2024, with information gathered through 04/02/2024, Surveyors conducted a standard licensure survey and 3 complaint investigations at The Koselig House. Twelve deficiencies were identified. Two of 3 complaints were substantiated. N0301 DHS 83.28(3) Provide Admission Agreement as Required N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0355 DHS 83.32(3)(k) Rights of Residents: Self-Determination N0364 DHS 83.33(3) Assistance With Grievance Procedure N0383 DHS 83.35(1)(c) Listed Areas For Assessments N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan. This is a repeat deficiency. See SOD BNOK11, dated 02/17/2022, N0408 DHS 83.37(1)(i) PRN Psychotropic Medication N0415 DHS 83.37(2)(d) Documentation of Medication Administration N0417 DHS 83.37(3)(a) Medication Storage: Original Containers N0425 DHS 83.38(1)(a) Personal Care. This is a	{N 196}		

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{N 196}	Continued From page 17 repeat deficiency. See SOD 2U5411, dated 02/01/2023. N0432 DHS 83.38(1)(h) Medication Administration N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable. This is a repeat deficiency. See SOD 2U5R12, dated 06/01/2023. On 09/23/2024 at 9:00 AM, Surveyor interviewed Interim Administrator EE. Administrator EE stated s/he would be addressing all concerns immediately with staff and management.	{N 196}		
{N 205}	83.14(2)(j) Not permit a condition of substantial risk. The licensee may not permit the existence or continuation of any condition which is or may create a substantial risk to the health, safety or welfare of any resident. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not prohibit the existence of a condition which may create substantial risk to the welfare of residents. This is a repeat deficiency. See Statement of Deficiency (SOD) YSHR11, dated 06/06/2024. The provider's front doorbell that alerted staff that visitor(s) or emergency personnel had arrived at the facility, was not loud enough for staff to hear unless they were standing in the common area which was located near the facility entrance. Resident 3, Resident 4, and Resident 5 were	{N 205}		

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two-person assists and the provider only had one staff member scheduled.

Findings include:

The provider received a regular license on 10/01/2022, as a class CNA (nonambulatory) CBRF able to serve up to 40 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, terminally ill, and physically disabled.

Example 1: Doorbell

On 09/09/2024, at approximately 9:00 AM, Surveyors arrived at the facility and attempted to enter the building. The building is a secured facility, and visitors are required to ring a doorbell to alert staff. There were two doorbells and Surveyors pressed both. As Surveyors waited, Life Enrichment Aid X arrived at the facility and assisted Surveyors into the building.

On 09/09/2024, at approximately 1:30 PM, Surveyors interviewed Resident Care Manager (RCM) Y. Surveyor asked how staff were alerted when an individual was trying to enter the facility. RCM Y explained that staff were to carry a phone with them, so they are alerted when the doorbell had been rung, because staff are unable to hear the doorbell if they are in a resident room. RCM Y then opened the front door for Surveyors to see how the alert was displayed on the phone. RCM Y explained that there are two doorbells available for an individual to press, but only one of the doorbells would register on the phone. Surveyor also walked down the hall corridor where the resident rooms were located to determine if the doorbell could be heard if a staff member did not have a phone. Surveyor was unable to hear the

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doorbell. RCM Y stated there were two telephones, so if there were more than 2 staff on schedule, then some staff would not know the front doorbell had been rung.

On 09/19/2024, at approximately 5:40 PM, Surveyor interviewed agency staff Caregiver DD. Caregiver DD stated s/he did not have a phone, as there were only two phones and there were currently 4 staff on schedule. Caregiver DD stated s/he would not know if the front doorbell rang unless s/he was in the common area and saw somebody at the door.

On 09/23/2024 at 9:00 AM, Surveyor interviewed Interim Administrator EE. Interim Administrator EE stated s/he started with the provider on 09/20/2024 and s/he had located two more phones that staff should be and would be utilizing to ensure prompt response to doorbells.

Example 2: Staffing Levels

On 09/09/2024, at approximately 1:00 PM, Surveyor observed Resident 4 lying in his/her bed in his/her room. Surveyor interviewed Resident 4's Power of Attorney (POA) T who stated Resident 4 was transferred with a Hoyer lift as s/he no longer had the strength to stand on his/her own.

On 09/09/2024, Surveyor requested and reviewed the August 2024 staff schedule from Administrator O.

On 09/09/2024, at approximately 2:30 PM, Surveyor interviewed Administrator O. Surveyor requested clarification on how the scheduling was determined as the August 2024 schedule showed shifts that were not covered and shifts that only

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scheduled one caregiver. Administrator O stated, "I am pretty sure all shifts are covered. We utilize agency staff, so we rely on them to pick up the open shifts." Surveyor requested the complete September 2024 staff schedule and to ensure agency staff were documented on the schedule.

On 09/09/2024, at approximately 2:40 PM, Surveyor interviewed Resident Care Manager (RCM) Y. RCM Y stated scheduling was difficult due to the staffing shortages.

On 09/13/2024 at 12:11 PM, Resident 4's POA T emailed Surveyor and informed him/her that Resident 4 had passed. POA T forwarded a video clip of a staff member independently transferring Resident 4 in a Hoyer.

On 09/18/2024, Surveyor reviewed the September 2024 staff schedule, dated 09/01/2024 to 09/18/2024, which documented:
09/01/2024 - 6:00 AM to 2:30 PM - One Caregiver
09/03/2024 - 2:30 PM to 5:00 PM; 10:30 PM - 6:30 AM - One Caregiver
09/12/2024 - 2:30 PM to 5:00 PM - Only a housekeeper is scheduled; 5:00 PM to 6:00 PM - No caregivers are scheduled
09/15/2024 - 10:30 PM to 6:30 AM - One Caregiver
09/16/2024 - 6:30 AM to 12:00 PM - One Caregiver
09/17/2024 - 2:30 PM to 6:00 PM - No Caregiver is scheduled
09/18/2024 - 6:30 AM to 2:30 PM - One Caregiver; 2:30 PM to 6:00 PM - No Caregiver is scheduled

On 09/18/2024 at 1:06 PM, Surveyor emailed Administrator O and requested clarification on the

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staffing schedule. Administrator O stated s/he would have RCM Y review the documentation and correct as necessary.

On 09/18/2024, at approximately 1:15 PM, Surveyor interviewed hospice Registered Nurse (RN) CC. RN CC stated, "We have to schedule 2 hospice CNA's (certified nursing assistants) for any Hoyer lifts because they never have staff to help. This happened again on Monday (09/16/2024), we wasted 30 minutes during the resident's visit trying to find assistance."

On 09/19/2024, at approximately 4:40 PM, Surveyor observed Resident 3 in his/her room. Resident 3 had been calling out for help. Surveyor observed two staff members walk into his/her room to assist.

On 09/19/2024, at approximately 5:00 PM, Surveyor observed Resident 5, sitting at the dining table in a Broda chair.

On 09/20/2024, Surveyor reviewed Resident 3's, Resident 4's, and Resident 5's record.

Resident 3's "Care Plan," undated, documented: "Toileting Program - Full Assist: Staff to assist with 2 assist pivot transfer for all transfers."

Resident 4's "Service Plan," undated, documented:
"Transfer - Staff Assistance: Effective 04/11/2023 due to increased weakness due to knee issues, [s/he] now requires two staff assist for all transfers."

Resident 5's "Service Plan," undated, documented:
"Transfer - 2 person Hoyer."

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{N 205}	Continued From page 22 As of 09/20/2024 at 5:00 PM, Surveyor did not receive a response or any additional documentation from Administrator O or RCM Y. On 09/23/2024, at approximately 10:15 AM, Surveyor interviewed hospice Certified Nursing Assistant (CNA) II and hospice CNA JJ. CNA JJ stated that the provider was understaffed and when s/he arrived to provide showering services to hospice residents, s/he could wait up to 45 minutes for a staff member to assist them. CNA JJ stated, "You call the house phone, nobody answers, you walk around the facility, you cannot find any staff. It is very frustrating." Cross Reference: N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment	{N 205}		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on observation, record review and interview, Administrator O did not provide the	N 214		

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supervision necessary to ensure the residents received proper care and treatment.

Findings include:

On 09/09/2024, with information gathered through 10/14/2024, Surveyors conducted 2 verification visits and 3 complaint investigations alleging residents were not provided adequate care. As a result of the survey, 23 deficiencies were identified regarding administrator duties:

N0161 83.12 (3)(a) Investigate Injuries of Unknown Source
N0165 83.12(4)(c) Reporting Incidents With Serious Injury
N0205 83.14(2)(j) Not Permit A Condition Of Substantial Risk
N0247 83.22(1)-(4) Task Specific Training
N0348 83.32(3)(d) Rights of Residents: Free From Mistreatment
N0352 83.32(3)(h) Rights of Residents: Receive Medication
N0383 83.35(1)(c) Listed Areas For Assessments
N0387 83.35(3)(b) Service Plan Development: Parties Involved
N0388 83.35(3)(c) Implement, Follow The Individual Service Plan
N0389 83.35(3)(d) Service Plans Updated Annually or On Changes
N0406 83.37(1)(g) Disposition of Medications
N0408 83.37(1)(i) PRN Psychotropic Medication
N0415 83.37(2)(d) Documentation of Medication Administration
N0416 83.37(2)(e) Other Administration Given Or Delegated by RN
N0425 83.38(1)(a) Personal Care
N0431 83.38(1)(g) Health Monitoring
N0448 83.41(2)(a) Nutrition: Diet
N0450 83.41(2)(c) Nutrition: Menus

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N 214	Continued From page 24 N0452 83.41(3)(b) Food Safety N0481 83.43(1) Environment Safe, Clean, And Comfortable N0489 83.44(2)(a) Rooms Clean and Free From Odors Y3234 50.09(1)(e) Treatment Z0010 1-50.065(2)(bb) Determine Final Disposition of Charge On 09/09/2024, at approximately 3:00 PM, Surveyor interviewed Administrator O. Administrator O stated s/he had been struggling to maintain a permanent administrator for the building. Administrator O stated s/he is the administrator on record and relied on staff who are in the building to keep him/her informed. On 09/23/2024 at 9:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he had started with the provider on 09/20/2024 and would be addressing the concerns identified. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 214		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment.	N 247		

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N 247	Continued From page 25 Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure employees obtained all task specific training. Resident 5 sustained significant bruising on his/her legs which was alleged to be caused from Hoyer transferring due to staff not properly trained in Hoyer transfers. Findings include:	N 247		

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The provider received a regular license on 10/01/2022, as a class CNA (nonambulatory) CBRF able to serve up to 40 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, terminally ill, and physically disabled.

On 09/18/2024, at approximately 1:15 PM, Surveyor interviewed hospice RN CC. RN CC stated Resident 5 had sustained significant bruising on his/her legs and s/he believed it was due to inappropriate and/or inexperienced Hoyer transferring. Surveyor requested Resident 5's hospice documentation.

On 09/18/2024, Surveyor reviewed Resident 5's record.

Resident 5 moved into the facility on 04/25/2023.

Resident 5's "Incident Report," documented: 08/28/2024 - Staff was laying resident down and took off [his/her] ted hose stockings and observed 2 really large sized bruises so staff notified hospice [his/her] family and management. [RN CC] nurse came out to observe [him/her] and look [him/her] over [s/he] said its fine and [s/he] looks normal the bruising looks like a transfer injury and just to be careful not to hit [him/her] on anything during transfers.

On 09/20/2024 at 3:55 PM, Surveyor emailed interim Administrator EE. Surveyor requested Hoyer training records for Caregiver AA, Med Passer BB, Caregiver FF, and Caregiver GG.

On 09/23/2024 at 9:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he had started with the provider on

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09/20/2024 and s/he would need to reach out to Administrator O to determine if the staff had received Hoyer training. Administrator EE stated s/he was working with hospice to set up Hoyer training and to re-educate staff that a Hoyer lift is always a 2-person assist.

As of 09/23/2024 at 5:00 PM, Surveyor did not receive any training records.

On 09/25/2024, Surveyor reviewed Resident 5's hospice records which documented:
"08/15/2024 - ... [s/he] is not a high fall risk due to not walking around and now relying on a Hoyer for transfers."
"08/28/2024 - [Caregiver FF] calls and reports that facility director would like a [hospice RN] to make visit tonight. [Caregiver FF] reports that [s/he] removed patient's TED hose (surgical stockings) tonight and found 2 "really big" bruises to patient's legs which were not there this morning. ... Reports bruise to left leg is small, but bruising to right leg is "very big and swollen." PT (patient) unable to verbalize pain, but no non-verbal s/sx (signs/symptoms) of pain noted. ... Patient is typically in Broda chair and staff does not know how patient obtained these bruises. ... Additional comments: 8cm (centimeters) x 5 cm bruise to right lower medial shin. ... Likely occurred during a pt transfer as pt non ambulatory and Hoyer lift only. ... Writer provided education to staff to be careful with pt transfers as to not have pt's legs strike anything on transfers as [s/he] is at higher risk for bruising and bleeding because [s/he] is on blood thinners."
"08/30/2024 - Writer asked about patient's new found bruise. [Caregiver FF] feels this is a result of a transfer and reports that staff don't all know how to properly use lifts and there is high turnover, so it's hard to gauge who knows how to

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N 247	Continued From page 28 use lifts properly." Cross Reference: N0161 DHS 83.12 (3)(a) Investigate Injuries of Unknown Source. Cross Reference: N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan	N 247		
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 interviews and record review, the provider did not ensure residents were free from physical or mental abuse or neglect. Caregiver AA was witnessed by Caregiver Z verbally and physically abusing Resident 4. Findings include: The provider is licensed for a community based residential facility (CBRF), Class CNA (nonambulatory), to serve up to 40 residents within the client groups advanced aged, irreversible dementia/Alzheimer's, terminally ill, and physically disabled. Neglect, as defined in Wisconsin Statue 46.90(1)	N 348		

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(f), is the failure of a Resident Care Aide to try to secure or maintain adequate care, services or supervision for an individual, including food, clothing, shelter, or physical or mental health care. Neglect can be an act, omission, or course of conduct and creates significant risk or danger to the individual's physical or mental health. Physical abuse, as defined in Wisconsin Statue 46.90(1)(fg), means the intentional or reckless infliction of bodily harm.

On 09/09/2024, at approximately 11:15 AM, Surveyor interviewed Resident 4's Power of Attorney (POA) T. POA T stated s/he had been informed by a staff member that a caregiver had verbally and physically assaulted Resident 4. POA T was informed by Administrator O that an investigation would occur.

On 09/09/2024, at approximately 1:15 PM, Surveyors interviewed Resident Care Manager (RCM) Y. RCM Y stated Caregiver Z had provided him/her with a written statement on 08/28/2024 of an observation s/he had observed between Caregiver AA and Resident 4. RCM Y stated Caregiver AA stopped coming to work when the investigation started and had moved to another state. Surveyor requested a copy of the statement.

On 09/09/2024, Surveyor reviewed Caregiver Y's statement which documented:
"On 08/23/2024 at approximately 3 PM, [Resident 4] had rang [his/her] pendant over 10 times so I decided that because we only had an hour and a half until dinner, and 4 team members here, that I would bring [Resident 4] down to the dining room. As we were not able to do a 1 on 1 w/resident (with resident) at the time I began walking down to grab [him/her] as [Caregiver AA] came

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storming down the hall claiming that [s/he] would do it because [s/he] had just gone into room a couple minutes prior. [Caregiver AA] walked into room and began telling [Resident 4] [s/he] was ringing too much and to 'shut up, I have had enough of this you are coming with me.' [S/he] then ripped off [his/her] blanket and aggressively put [Resident 4] in [his/her] wheelchair, [Resident 4] was confused so [s/he] began asking if it was dinner time or why [s/he] had to get up and [Caregiver AA] started wheeling [him/her] down and silencing [him/her] by yelling in [his/her] face that [s/he] was misbehaving so [s/he] was getting punished. Once resident was in common area [s/he] began asking for help when [Caregiver AA] again told [him/her] to shut up and that [s/he] wouldn't get help until [s/he] stopped ringing."

On 09/15/2024, Surveyor reviewed the written report Administrator O had submitted to the Office of Caregiver Quality which documented: "Upon notification of the incident, writer and [RCM Y] interviewed [Caregiver AA] and asked [him/her] if [s/he] was aware of any incidents involving staff telling a resident to "shut-up" or transfer any resident aggressively. [S/he] denied it. Then I asked [him/her] if any incident occurred between [her/him] and a resident where [s/he] got frustrated, [s/he] denied it. [S/he] then interrupted me and said this was all a set-up because [s/he] had some personal issues outside of the community with [RCM Y]. [RCM Y] immediately denied this and stated this statement was made by another staff person that had nothing to do with them and had no relationship with [her/him]. I then asked [Caregiver AA] in detail about whether on 08/23 any incident occurred with any resident. [S/he] denied it. I then asked [him/her] if [s/he] had gone to assist [Resident 4]. [S/he] confirmed [s/he] had. I then

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asked [him/her] if [s/he] ever stated to [Resident 4] to "shut up" or if [s/he] ever got frustrated with [him/her]. [S/he] denied it and stated if [s/he] were frustrated [s/he] knows better and would ask another caregiver to step in. [S/he] then stated nothing at all occurred with [Resident 4] and that [s/he] would never harm another resident. I asked [him/her] to write up a statement and scheduled a sit down interview. [S/he] resigned and did not submit a statement. Upon interview of [Caregiver Z], [s/he] confirmed [his/her] written statement verbatim. [S/he] confirmed [s/he] had attended Abuse, Neglect, misappropriation training and knew [s/he] was supposed to report to me but failed to do so because of the outside friendship that was outside of the community. [S/he] also denied reporting it to any staff that night but a few days later discussed with [Caregiver MM]. [S/he] relayed that at the time of the incident, [s/he] did attempt to redirect [Caregiver AA] and tell [him/her] that [s/he] was not acting appropriately and to stop but [Caregiver AA] continued. No family member or resident reportedly heard the incident. [Caregiver MM] upon interview denied having any first hand knowledge of the situation, but self-termed prior to giving [his/her] written statement.

On 09/23/2024 at 9:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he had contacted the ombudsman to arrange resident rights training. Administrator EE stated, "Staff should understand that anytime they witness any form of abuse, they need to report that immediately."

On 10/12/2024, Detective L from the local police department, emailed Surveyor his/her reports regarding Resident 4, which documented: "On September 21, 2024, ... [Caregiver Z] stated

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N 348	Continued From page 32 [s/he] has never worked with someone who got so angry about little things so [s/he] told [Caregiver AA] it was okay, and [s/he] would get [Resident 4]. [Caregiver Z] stated [Caregiver AA] walked into [Resident 4's] room and told [Resident 4] to 'Shut Up, I have had enough of this you are coming with me.' [Caregiver Z] advised [Resident 4] was sitting in [his/her] recliner and has a difficult time hearing. [Caregiver Z] advised [s/he] then bent down on [Resident 4's] right side (from [Resident 4's] perspective) and started to talk to [Resident 4] about ringing [his/her] pendant too much and [Caregiver Z's] plan to bring [Resident 4] to the dining room early. ... [Caregiver Z] stated [s/he] was still trying to communicate with [Resident 4] as to the plan when [Caregiver AA] picked [Resident 4] up from [his/her] recliner and put [him/her] in the wheelchair. [Caregiver Z] then stated, 'It seemed more forceful than what was necessary.' [Caregiver Z] then explained while picking [Resident 4] up, [Caregiver AA] was facing [Resident 4] and [Caregiver AA] put [his/her] feet in front of [Resident 4]. [Caregiver Z] stated [Caregiver AA] bent down and put [his/her] hands under [Resident 4's] armpits and 'scooped [him/her] up.' [Caregiver Z] later stated [Caregiver AA] 'forcefully' put [Resident 4] into the wheelchair and [Caregiver Z] stated, 'it felt like [s/he] was using force to do it." [Caregiver Z] stated [Caregiver AA] brought [Resident 4] all the way down, but [Resident 4] did not comfortably sit in the chair. [Caregiver Z] stated [Caregiver AA] then did not readjust [Resident 4] after being placed in the wheelchair. I asked [Caregiver Z] why [Resident 4] was not comfortably sitting in the wheelchair and [Caregiver Z] stated [s/he] assumed [Resident 4's] buttock was hurting and [Resident 4's] body was leaning off to one side of the wheelchair. ..."	N 348		

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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 administer medications in the intervals prescribed by a practitioner for 5 of 5 residents. This is a repeat deficiency. See Statement of Deficiency (SOD) T56511, dated 04/02/2024. Resident 4 did not receive his/her prescribed Dorzolamide-Timolol Eye Drops, Travoprost (eye drops), and Rhopressa (eye drops) due to non-availability. Resident 8 did not receive his/her Hydralazine (blood pressure medication), Acetaminophen (pain medication), and Metoprolol ER (extended release) (blood pressure medication) as prescribed due to non-availability. Resident 12 did not receive his/her Fluticasone-Salmeterol as prescribed. Resident 15 received Memantine (Alzheimer's medication) and Donepezil (Alzheimer's medication) for 17 days when the medication had been discontinued. Resident 16's prescribed Desitin was not administered due to non-availability. Findings include:	N 352		

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On 09/09/2024, Surveyor requested from Administrator O Resident 4's, Resident 8's, Resident 12's and Resident 16's record. Administrator O forwarded the requested documentation and stated, "When auditing the MARs (medication administration record) I am sending you, we have identified that we have staff marking off that they are ordering meds through ECP (electronic computer program), however, they weren't delivered. We discovered through investigation that they didn't have the correct profile to have that communication actually go to the pharmacy. It looked ordered on our side but wasn't going to the pharmacy. We repaired this issue this morning when we discovered it and will send an update to family and MD (medical doctor) for any missed medications."

On 09/14/2024, Surveyor reviewed Resident 4's, Resident 8's, Resident 12's and Resident 16's record.

Example 1: Resident 4

Resident 4 moved into the facility 11/24/2021.

Resident 4's August 2024 Medication Administration Record (MAR) documented:
"Dorzolamide-Timolol Eye Drops. Instill (1) drop into both eyes twice daily. Scheduled at 7:00 A and 8:00 PM. Start Date: 07/13/2023."
08/14 8:00 PM - Other - Med is out ordered.
08/15 7:00 AM - Other - Medication expired, new script on order; 8:00 PM - Other - Med is out.
08/16 7:00 AM - Other - Out of medication; 8:00 PM - Other - Med is out.
08/17 7:00 AM - Other - Med expired and was pulled from cart; 8:00 PM - Other - Med is out. Ordered.
08/18 7:00 AM - Other - Out of medication; 8:00

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N 352	Continued From page 35 PM - Other - Med is out. Ordered. 08/19 7:00 AM - Other - Out of medication; 8:00 PM - Other - Med is out. Ordered. 08/20 7:00 AM - Other - Out of medication; 8:00 PM - Other - Med is out. Ordered. 08/21 7:00 AM - Other - Med is out. 08/22 7:00 AM - Other - Med is out; 8:00 PM - Other - Med is out. 08/23 7:00 AM - Other - Out of medication; 8:00 PM - Other - Med is out. 08/24 7:00 AM - Other - Waiting on pharmacy; 8:00 PM - Other 08/25 7:00 AM - Other - On order. 08/26 7:00 AM - Other - Med is out; 8:00 PM - Other - Med is out. Waiting on delivery. The MAR documented the medication had been administered on 08/21/2024 and 08/25/2024 at 8:00 PM when the medication had been documented as unavailable. "Rhopressa. Instill (1) drop into the right eye once daily. Scheduled at 8:00 PM. Start Date: 07/20/2023." 08/26 - Other - out med waiting on delivery 08/27 - Other - No rationale documented 08/28 - Other - No rationale documented 08/29 - Other - out of med 08/30 - Other - No rationale documented 08/31 - Other - No rationale documented "Travoprost. Instill (1) drop into both eyes daily at bedtime. Scheduled at 8:00 PM. Start Date: 07/20/2023." 08/14 - Other - Med is out ordered 08/15 - Other - Med is out 08/16 - Other - Med is out 08/17 - Other - Med is out - ordered 08/18 - Other - Med is out - ordered 08/19 - Other - Med is out - ordered 08/20 - Other - Med is out - ordered	N 352		

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08/22 - Other - Med is out
08/23 - Other - Med is out
08/24 - Other - No rationale documented
08/26 - Other - Out of med - waiting on delivery
08/27 - Other - No rationale documented

The MAR documented the medication had been administered on 08/21/2024 and 08/25/2024 when the medication had been documented as unavailable.

Example 2: Resident 8

On 09/19/2024, Surveyor reviewed Resident 8's record.

Resident 8 moved into the facility on 09/14/2023.

Resident 8's August 2024 MAR documented:
"Hydralazine 25 mg (milligram) tablet. Take (1/2) tablet orally twice daily. Scheduled for 8:00 AM and 8:00 PM. Start date: 09/14/2023.
08/01 7:21 AM- Other- Not in cart; 8:07 PM- Other- Medication not in med cart.
08/02 6:44 AM- Other- out of med; 6:17 PM- Other- Not in cart.
08/03 7:58 AM- Other- Not in cart; 8:05 PM- Other.
08/04 8:23 AM- Other; 8:05 PM- Other.
08/05 7:40 AM- Refused by resident- Not in med cart; 7:42 PM- Other."
There was not a "no pass" reason provided for the evening dose on 08/03 or either dose on 08/04.

"Metoprolol Er 50 mg tablet. Take (1) tablet orally twice daily. Scheduled for 8:00 AM and 8:00 PM. Start date: 06/04/2024.
08/01 7:22 AM- Other- Not med in cart; 8:06 PM- Other- Medication not in med cart.

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08/02 6:45 AM- Other- out of med; 6:17 PM- Other- Not in cart.
08/03 7:58 AM- Other- Not in cart; 8:05 PM- Other.
08/04 8:23 AM- Other; 8:05 PM- Other.
08/05 7:40 AM- Other- Not in med cart; 7:42 PM- Other."
There was not a "no pass" reason provided for the evening dose on 08/03 or either dose on 08/04.

"Acetaminophen 500 mg tablet. Take (1) tablet orally twice daily. Scheduled for 8:00 AM and 5:00 PM. For pain. Start date: 04/10/2024.
08/01 6:53 AM- Other- Out of medication; 4:49 PM- Other- Out of medication.
08/02 6:44 AM- Other- out of med; 3:41 PM- Other- Not in med cart.
08/03 7:59 AM- Other- Not in cart; 5:00 PM- Other- Waiting on pharm.
08/04 8:22 AM- Other; 5:07 PM- Other.
08/05 5:16 PM- Other."
There was not a "no pass" reason provided for either dose on 08/04 or for the evening dose on 08/05. The morning dose on 08/05 was documented as given when the medication had been documented as unavailable.

Example 3: Resident 12

On 09/09/2024, at approximately 11:30 AM, Surveyors observed the medication cart with Caregiver BB. Surveyor observed Resident 12's Fluticasone-Salmeterol which was documented as opened 07/17/2024 and displayed 2 out of 60 remaining doses.

On 09/14/2024, Surveyor reviewed Resident 12's July, August, and September 2024 MARs, dated 07/01/2024 to 09/08/2024, which documented:

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Fluticasone-Salmeterol 100-50. Inhale (1) puff orally twice daily. May not use after thirty days after removing from foil package.
The July MAR documented that the medication had been administered 29 out of 30 opportunities (15 days).
The August MAR documented that the medication had been administered 62 out of 62 opportunities (31 days).
The September MAR documented that the medication had been administered 16 out of 16 opportunities (8 days).

Surveyor noted 30 days would have been 08/17/2024 and the inhaler should have been discarded due to expiration and due to no remaining doses.

Example 4: Resident 15

On 09/18/2024, at approximately 1:15 PM, Surveyor interviewed hospice Registered Nurse (RN) CC. RN CC stated Resident 15's Memantine and Donepezil had been discontinued. RN CC stated Resident 15 continued to receive the medications for 17 days until RN CC physically removed the blister cards from the med cart. Surveyor requested Resident 15's hospice records.

On 09/18/2024, Surveyor requested Resident 15's record from Administrator O.

Resident 15 admitted to the facility, 02/06/2024, with diagnosis including dementia without behavioral disturbance.

Resident 15's August 2024 Medication Administration Record (MAR) documented: "Memantine - Take 1 Tablet Orally Twice Daily.

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Start Date: 02/06/2024. End Date: 08/26/2024."
"Donepezil - Take 1 Tablet Orally Once Daily at Bedtime. Start Date: 02/06/2024. End Date: 08/26/2024."

On 10/15/2024, Surveyor reviewed Resident 15's hospice records which documented:
"08/05/2024 - Writer also notes that Memantine and Donepezil are present on MAR and were administered today. Writer informed [Caregiver GG and Caregiver RR] that medications were discontinued on Friday and a
copy of the discontinued orders were both faxed and emailed to the facility. [Caregiver GG and Caregiver RR] report that this will have to be changed by [Resident Care Manager Y] and that they are unable to remove medication from med list. [Resident Care Manager Y] is currently not working so they will write a note for [him/her] when [s/he] comes in this afternoon."
"08/19/2024 - Writer notes that Memantine and Donepezil are still on patient's MAR after numerous faxes, emails, phone calls and a face to face conversation with [Resident Care Manager Y] on Friday. Writer and [Caregiver AA] completed a medication disposal form and destroyed remaining donepezil and memantine."

Example 5: Resident 16

Resident 16 moved into the facility 08/11/2020.

Resident 16's September 2024 MAR, dated 09/01/2024 to 09/09/2024, documented:
"Desitin 40% Paste - Apply to affected area(s) of perineal area three times daily. Scheduled at 7:00 AM, 2:00 PM, 8:00 PM. Start Date: 04/17/2024."
09/01 7:45 AM - med not available
09/01 11:42 AM - not using this cream but has

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N 352	Continued From page 40 been using another barrier cream 09/02 7:50 PM - No med in cart 09/03 7:58 PM - Not in med cart 09/04 2:03 PM - None in cart 09/09 9:14 PM - Out of medication On 09/23/2024 at 9:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he would be arranging training so that all med-passers would be re-educated.	N 352		
N 383	83.35(1)(c) Listed areas for assessments. Assessment. Areas of assessment. The assessment, at a minimum, shall include all of the following areas applicable to the resident: 1. Physical health, including identification of chronic, short-term and recurring illnesses, oral health, physical disabilities, mobility status and the need for any restorative or rehabilitative care. 2. Medications the resident takes and the resident ' s ability to control and self-administer medications. 3. Presence and intensity of pain. 4. Nursing procedures the resident needs and the number of hours per week of nursing care the resident needs. 5. Mental and emotional health, including the resident ' s self-concept, motivation and attitudes, symptoms of mental illness and participation in treatment and programming. 6. Behavior patterns that are or may be harmful to the resident or other persons, including destruction of property. 7. Risks, including, choking, falling, and elopement. 8. Capacity for self-care, including the need for any personal care services, adaptive equipment or training. 9. Capacity for self-direction, including the ability to make decisions, to act independently and to make wants or needs known. 10. Social participation, including interpersonal	N 383		

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relationships, communication skills, leisure time activities, family and community contacts and vocational needs.

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure 4 of 4 resident assessments, at a minimum, included all the areas applicable to the resident risks, including, the use of adaptive equipment.

This is a repeat deficiency. See Statement of Deficiency (SOD) T56511, dated 04/02/2024.

Resident 14, Resident 15, Resident 19 and Resident 20 utilized bedrails and their records did not include a bedrail assessment.

Findings include:

The facility can provide cares for up to 40 residents in the client groups: irreversible dementia, Alzheimer's, advanced aged, terminally ill, and physically disabled.

On 09/09/2024, from approximately 9:00 AM to 3:30 PM, Surveyors observed the following residents utilizing bedrails in their rooms:
-Resident 14, had a half-length rail in the up position.
-Resident 15, had a half-length rail in the up position.
-Resident 19, had a half-length rail in the up position.
-Resident 20, had a half-length rail in the up position.

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N 383	Continued From page 42 Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings: "Individualized Patient Assessment Any decision regarding bed rail use or removal from use should be made within the framework of an individual patient assessment. If a bed rail has been determined to be necessary, steps should be taken to reduce the known risks associated with its use. Sleeping environment assessment This assessment includes elements or conditions that may affect the patient's ability to sleep and may be considered in evaluating areas to address in a patient's care plan. Treatment Programs/Care Plans -Address diagnoses, symptoms, conditions, and/or behavioral symptoms for which the use of a bed rail is being considered. -Identify nursing/medical and environmental interventions (e.g., for a patient with a life-long habit of staying up at night, provide nighttime activity). -If clinical and environmental interventions have proven to be unsuccessful in meeting the patient's assessed needs or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be used. Documentation of the risk-benefit assessment should be in the patient's medical chart. -The team should review the treatment program and determine its effects on the patient through an ongoing cycle of evaluation that includes assessment of outcomes and adverse effects. -When planning care for the patient for whom a	N 383		

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low bed is selected, consideration should be given to potential effects on the patient such as restraining desired voluntary movement or creating an unwanted psychological effect by being placed close to the floor. The individualized care plan and risk benefit considerations should address these issues and the plan modified accordingly." (Source: Restraints- Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings., 2003, https://www.dhs.wisconsin.gov/regulations/assisted-living/standards.htm (retrieval date- September 20, 2024).)

On 09/09/2024, Surveyors requested Surveyors requested Resident 14's, Resident 15's, Resident 19's and Resident 20's record including bedrail assessments from Administrator O. Administrator O stated s/he was unable to locate the assessments and would forward them to the Surveyors.

On 09/19/2024, Surveyors reviewed Resident 14's, Resident 15's, Resident 19's and Resident 20's record.

Example 1: Resident 14
Resident 14 admitted to the facility, 10/11/2018, with diagnoses including Lewy body dementia and osteoporosis.

Resident 14's "Care Plan," undated, documented: "Frequent Monitoring: Resident does not have a pendant in place. Care Staff will provide purposeful rounds frequently (while [Resident 14] is awake) to assist."
"Behavior - Hallucinations: [Resident 14] has Lewy Body Dementia and becomes anxious with

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hallucinations."
"Sleep/Wake Cycle: Often has [his/her] days and nights mixed up.

There was no evidence of a bed rail assessment in Resident 19's file and his/her care plan did not reflect the use of bed rails.

Example 2: Resident 15

Resident 15 admitted to the facility, 02/06/2024, with diagnosis including dementia without behavioral disturbance.

Resident 15's "Care Plan," undated, did not documented guidance regarding sleep patterns and/or behaviors.

There was no evidence of a bed rail assessment in Resident 19's file and his/her care plan did not reflect the use of bed rails.

Example 3: Resident 19

Resident 19 admitted to the facility on 03/27/2024.

Resident 19's "Care Plan," undated, documented: "Sleep/Wake Cycle: Care Team to assist Resident, as needed, with orientation to day/night."

There was no evidence of a bed rail assessment in Resident 19's file and his/her care plan did not reflect the use of bed rails.

Example 4: Resident 20

Resident 20 admitted to the facility on 01/16/2024.

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N 383	Continued From page 45 Resident 20's "Service Plan," undated, documented: "Behavior - Aggressive/Combative: Resident may become agitated and swat at staff when [s/he] does not want to do something or when [s/he] cannot vocalize [his/her] needs/wants." "Fall Risk 3 - High Risk: [Resident 20] has poor safety awareness and often will attempt to self-transfer." There was no evidence of a bed rail assessment in Resident 19's file and his/her service plan did not reflect the use of bed rails. As of 09/20/2024 at 5:00 PM, Surveyors did not receive any additional documentation. On 09/23/2024 at 9:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE reviewed the resident records in the electronic computer system and confirmed that bedrail assessments had not been utilized. Administrator EE stated s/he would assess each resident and update their record.	N 383		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in	N 387		

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cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the resident's Individual Service Plan (ISP) was signed by the resident or resident's legal representative acknowledging their involvement in, understanding of, and in agreement with the plan for 5 of 5 residents (Resident 3, Resident 4, Resident 9, Resident 10, and Resident 11).

This is a repeat deficiency. See Statement of Deficiency (SOD) GRGR11, dated 06/02/2022.

Findings include:

On 09/09/2024, Surveyor requested and reviewed Resident 3's, Resident 4's, Resident 9's, Resident 10's, and Resident 11's record.

Resident 3 moved into the facility on 11/10/2021 and is represented by Power of Attorney (POA) U and managed care organization (MCO) Case Manager (CM) V.
Resident 3's, "Care Plan (ISP)," undated, had not been signed by the provider, POA U, or CM V.

Resident 4 moved into the facility on 11/24/2021 and is represented by POA T.
Resident 4's, "Care Plan (ISP)," undated, had not been signed by the provider or POA T.

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N 387	Continued From page 47 Resident 9 moved into the facility on 09/12/2019 and is represented by POA S. Resident 9's, "Care Plan (ISP)," undated, had not been signed by the provider or POA S. Resident 10 moved into the facility on 02/23/2024 and is his/her own person. Resident 10's, "Care Plan (ISP)," undated, had not been signed by the provider or Resident 10. Resident 11 moved into the facility on 06/22/2022 and is represented by POA W. Resident 11's, "Care Plan (ISP)," undated, had not been signed by the provider or POA W. On 09/09/2024, at approximately 3:00 PM, Surveyors interviewed Administrator O. Administrator O stated s/he was unable to locate signature pages for any of the ISPs. On 09/23/2024 at 9:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he was unable to locate any ISP signature pages and would address the concern.	N 387		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not follow 2 of 2 resident's Individual Service Plan (ISP) as written. This is a repeat deficiency. See Statement of Deficiency (SOD) GNOK11, dated 02/17/2022,	N 388		

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and SOD T56511, dated 04/02/2024.

Resident 3 was documented on his/her ISP that s/he was to be encouraged fluids throughout the day for urinary tract infection (UTI) prevention. Resident 3's water cup was not placed within reach for him/her to utilize. Resident 3 is a fall risk and would have to self-transfer to reach the water cup.

Resident 3 was documented on his/her ISP that s/he was to wear Tubi-grip stockings throughout the day which was not implemented.

Resident 4 was documented as a two-person assist and s/he was transferred as a one-person assist.

Findings include:

The provider is licensed to care for up to 40 residents in the client groups terminally ill, physically disabled, advanced aged, and irreversible dementia/Alzheimer's.

Example 1: Resident 3

On 09/09/2024, at approximately 3:10 PM, Surveyors observed Resident 3, Hospice Registered Nurse (RN) CC, and Resident 3's Power of Attorney (POA) U, in Resident 3's bedroom. Surveyors were informed that Resident 3 was blind in his/her right eye and experienced limited movement/strength on his/her right side. Surveyor observed Resident 3 sitting in his/her recliner chair, next to the window and s/he had a small can of diet soda sitting on an overbed table, to the right of him/her. Resident 3 would have to lean out of his/her chair to turn and attempt to reach the can of soda. Surveyor asked Resident

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3's POA U if Resident 3 struggled to reach his/her beverage when placed to the right of him/her. POA U stated, "Yes, when staff assist him/her to move to his/her recliner chair, they do not make sure s/he has everything that s/he needs; and when staff come in to check on him/her, they do not ask about his/her water. I usually move it towards him/her when I get here." POA U then began to look for Resident 3's Tubi-sock as s/he was not wearing it. Surveyors asked RN CC if s/he had concerns with Resident 3 wearing his/her Tubi-sock consistently. RN CC stated, "Yes, [S/he] usually doesn't have it on and his/her edema has gotten worse."

On 09/10/2024, Surveyor reviewed Resident 3's record.

Resident 3 moved into the facility, 11/10/2021, with diagnoses included dementia, anxiety, and chronic obstructive pulmonary disease (COPD).

Resident 3's "Care Plan," undated, documented:
"Hydration/Nutrition Pass: A care team member will offer a snack in the afternoon as well as early evening which will include a beverage to assist with hydration."
"Transfer: Requires assistance of 1 staff with sit-to-stand lift at all times due to increased weakness."
"Behavior/Anxiety: Trying to get [him/herself] up."
"Edema Left Leg: Left Leg Elevation: Elevate left leg as much as possible."
"Tubi-Grips: A care team member will remove [Resident 3's] tubi grip stockings every evening. Once off the care team member will rise the tubi grips out in the sink."

Resident 3's "Annual Assessment," dated 01/14/2024, documented:

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"Hydration/Nutrition Pass: A care team member will offer a snack in the afternoon as well as early evening which will include a beverage to assist with hydration."
"Transfer: Requires assistance of 1 staff with sit-to-stand lift at all times due to increased weakness."
"Behavior/Anxiety: Trying to get [him/herself] up"
"Fall Risk 2 - Moderate Risk: There is a sign in [his/her] room reminding [him/her] to push pendant for assistance. 07/01/2023 fell trying to get a pillow off floor. Bed to be in lowest position possible to prevent injury from falls. continue purposeful rounds. 09/16/2023 attempted to transfer [him/herself]. Has reminder to use pendant, on purposeful rounds. eventually sent out for eval, treatment implemented during week for UTI treatment. 09/28/2023 fell during transfer with staff. Two assist for all transfers, if weak/unable to stand staff must use easy stand."

Resident 3's hospice notes documented:
08/08/2024 - Dyspnea (breathing difficulty) at rest when laying flat and edema (swelling caused by too much fluid trapped in the body's tissues) noted to right lower leg.
08/09/2024 - Patient has chronic discoloration to BLE (bilateral lower extremities) + 1 non pitting (a barely visible dent in the skin after applying pressure) edema to RLE (right lower extremity) from previous MVA (motor vehicle accident).
08/26/2024 - +1 pitting edema (a barely noticeable dent is left in the skin that rebounds immediately) to RLE and trace edema (a type of edema that's characterized by a pit that's 2 millimeters or less in depth and rebounds immediately) to LLE (left lower extremity).
09/09/2024 - Patient has chronic discoloration to BLEs and BUEs. +1 pitting edema to RLE and +1 non pitting edema to LLE.

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"Wearing compression garments and reducing salt in the diet often relieves edema. When a disease causes edema, the disease needs treatment, as well." (Source: Mayo Clinic Website, Edema, July 28, 2023, https://www.mayoclinic.org/diseases-conditions/edema/symptoms-causes/syc-20366493 (retrieval date - September 23, 2024).)

On 09/19/2024, at approximately 4:45 PM, Surveyor observed Resident 3 in his/her bedroom. Surveyor observed Resident 3 sitting in his/her recliner chair, next to the window and s/he had a small can of diet soda sitting on an overbed table, to the right of him/her. Resident 3 would have to lean out of his/her chair to turn and attempt to reach the can of soda.

On 09/23/2024, at approximately 10:50 AM, Surveyor observed Resident 3 sleeping in his/her recliner in his/her bedroom. Resident 3 did not have a beverage available.

On 09/23/2024, at approximately 11:40 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he would discuss these concerns with staff.

Example 2: Resident 4

On 09/09/2024, at approximately 1:20 PM, Surveyor interviewed Resident Care Manager Y. Resident Care Manager Y explained there was a situation where Caregiver AA was observed personally picking Resident 4 up and placing him/her aggressively into his/her wheelchair; Resident 4 was a Hoyer transfer. Surveyor requested Resident 4's record.

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On 09/10/2024, Surveyor reviewed Resident 4's record.

Resident 4 moved into the facility, 11/24/2021, with diagnoses including coronary artery disease, diabetic neuropathy, anxiety, cardiomyopathy (heart disease), osteoporosis, and lumbar disc herniation.

Resident 4's "Care Plan (ISP), undated, documented:
"Transfer - Staff Assistance: Requiring 2 staff with walker for transfers. [Resident 4] was previously a 1 person assist for transfers. Effective 04/11 due to increased weakness due to knee issues, [s/he] now requires two staff assist for all transfers."

On 09/13/2024 at 12:11 PM, Resident 4's Power of Attorney (POA) T emailed Surveyor and informed him/her that Resident 4 had passed. POA T forwarded a video clip of a staff member independently transferring Resident 4 in a Hoyer. POA T stated, "Yesterday, [Coroner LL], informed us during our long conversation that it is a state law that two people must operate a Hoyer lift when transferring an individual."

On 09/23/2024, at approximately 11:40 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he would discuss these concerns with staff.

On 10/12/2024, Detective L from the local police department, emailed Surveyor his/her reports regarding Resident 4, which documented:
"On September 21, 2024, ... I asked [Caregiver Z] to explain to me the August 23, 2024, incident involving [Caregiver AA] ... [Caregiver Z] then explained while picking [Resident 4] up,

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N 388	Continued From page 53 [Caregiver AA] was facing [Resident 4] and [Caregiver AA] put [his/her] feet in front of [Resident 4]. [Caregiver Z] stated [Caregiver AA] bent down and put [his/her] hands under [Resident 4's] armpits and 'scooped [him/her] up.' ... [Caregiver Z] stated [Resident 4] was to be moved with a Hoyer lift. ..." "On September 24, 2024, ... I spoke with [Caregiver K] ... [Caregiver K] stated staff is supposed to use the Hoyer lift, but staff does not use it as they should. [Caregiver K] explained staff will sometimes pivot transfer [Resident 4]. [Caregiver K] explained when [s/he] would pivot transfer [Resident 4], [s/he] would place [his/her] arms under [Resident 4's] armpits and lift [Resident 4]. [Caregiver K] stated there were times when [s/he] would arrive in the morning and [Resident 4's] sling would not be under [him/her] which means the Hoyer lift was not used. [Caregiver K] stated this happened often. [Caregiver K] stated the majority of people were not using the Hoyer lift." "On September 25, 2024, ... [Caregiver FF] stated the entire staff did not use the Hoyer lift as they should have been and were pivot transferring [Resident 4]." Cross Reference: N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment	N 388		
{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from	{N 389}		

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the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure 4 of 5 resident records reviewed were updated when there was a change in condition.

This is a repeat deficiency. See Statement of Deficiency (SOD) GRGR11, dated 06/02/2022, and SOD YSHR11, dated 06/06/2024.

Resident 3 was a Hoyer lift which was not documented in his/her Individual Service Plan (ISP).
Resident 5 could no longer ambulate independently which was not documented in his/her ISP.
Resident 9 and Resident 19 were on oxygen which was not documented in his/her ISP.
Resident 9's change in condition with incontinence was not documented in his/her ISP.

Findings include:

Example 1: Resident 3

On 09/09/2024, at approximately 3:10 PM, Surveyor observed Resident 3 in his/her room with hospice Registered Nurse (RN) CC and his/her Power of Attorney (POA) U. RN CC informed Surveyor that Resident 3 was now a

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Hoyer lift.

On 09/09/2024, at approximately 3:30 PM, Surveyors interviewed Administrator O. Surveyors asked, since the provider utilized primarily agency staff, how did staff know the proper care guidelines for each resident. Administrator O stated that at the end of each hall was a binder with task lists for each resident.

On 09/09/2024, at approximately 3:45 PM, Surveyors reviewed the binder Administrator O referenced.

Resident 3's "Service Plan Task," dated 02/12/2024, documented:
"Ambulation - Assist: Unable to self-propel in wheelchair. Requires the assistance with transfer."
"Bed Mobility - Stand By Assistance: Resident requires staff assistance with sit to stand lift with transfer sling."
"Fall Risk 2 - Moderate Risk: Transfer with mechanical lift."
"Transfer - Staff Assistance: Requires assistance of 1 staff with sit-to-stand lift at all times due to increased weakness.

On 09/09/2024, Surveyors requested Resident 3's record.

On 09/12/2024, Surveyor reviewed Resident 3's record.

Resident 3 moved into the facility 11/10/2021.

Resident 3's "Individual Service Plan (ISP)," undated, documented:
"Ambulation - Assist: Unable to self-propel in wheelchair. Requires the assistance with

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transfer."
"Bed Mobility - Stand By Assistance: Resident requires staff assistance with sit to stand lift with transfer sling."
"Fall Risk 2 - Moderate Risk: Transfer with mechanical lift."
"Transfer - Staff Assistance: Requires assistance of 1 staff with sit-to-stand lift at all times due to increased weakness.

On 09/23/2024 at 9:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he had replaced Administrator O on 09/20/2024 and was in the process of reviewing all resident records. Administrator EE stated there Resident 3 did not have a separate hospice ISP.

On 09/23/2024, Surveyor reviewed Resident 3's hospice documentation which read:
"08/09/2024 - Writer ordered Hoyer straps since pt (patient) would feel more comfortable in a Hoyer vs sit to stand."
"09/17/2024 - Pt (patient) is a Hoyer transfer."
"09/23/2024 - Writer collaborated with [hospice health aides] as they reported the patient did not have a sling under [him/her] in [his/her] recliner ... NOC shift had patient up without a sling this morning. Writer spoke to [interim Administrator EE] regarding sling not being under patient ... [Administrator EE] sent message to NOC shift lead to ensure all transfers are being done with Hoyer lift and sling is left under patient. "

Example 2: Resident 5

On 09/18/2024, at approximately 1:15 PM, Surveyor interviewed hospice RN CC. RN CC stated Resident 5 had sustained significant bruising on his/her legs and s/he believed it was

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due to inappropriate and/or inexperienced Hoyer transferring. Surveyor requested Resident 5's hospice records.

On 09/19/2024, at approximately 5:00 PM, Surveyor observed Resident 5, sitting at the dining table in a Broda chair.

On 09/20/2024, Surveyor requested and reviewed Resident 5's record.

Resident 5 moved into the facility 04/25/2023.

Resident 5's ISP, undated, documented:
"Ambulation - Assist: Resident requires assist with: [Resident 5] has walker and wheelchair. [S/he] uses wheelchair for mobility and distances. [Resident 5] is able to walk short distances with walker and 1 assist/supervision. [S/he] can walk from [his/her] recliner to bathroom and back. Should use wheelchair for long distances."
"Bed Mobility - Frequent Checks: Staff ensure that ambulatory device is next to the bed at night."
"Fall Risk 2 - Moderate Risk: Requires assistance for all transfers, due to cognitive impairment and need for assist with transfers."

On 09/23/2024 at 9:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he had replaced Administrator O on 09/20/2024 and was in the process of reviewing all resident records. Administrator EE stated there Resident 5 did not have a separate hospice ISP.

On 10/10/2024, Surveyor reviewed Resident 5's hospice records which documented:
"06/28/2024 - Ambulation: no change, non ambulatory."

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Example 3: Resident 9

On 09/19/2024, at approximately 5:20 PM, Surveyor toured Resident 9's room and observed an oxygen concentrator and oxygen tanks. Resident 9's oxygen nasal canula was lying on his/her bed.

On 09/20/2024, Surveyor requested and reviewed Resident 9's record.

Resident 9 moved into the facility, 09/12/2019, with diagnoses including intermittent asthma and coronary artery disease.

Resident 9's ISP, undated, did not document that s/he utilized oxygen.

Resident 9's hospice "Routine Standing Orders," dated 11/07/2022, documented:
"Oxygen orders: Oxygen via nasal cannula or mask at 0 L (liter) - 4 L per minute PRN (as needed) for dyspnea or labored breathing."

On 09/18/2024, at approximately 1:15 PM, Surveyor interviewed hospice Registered Nurse (RN) CC. RN CC stated, "[Resident 9] will usually be sitting in [his/her] incontinence when hospice arrives. I saw [him/her] 09/16/2024 and [s/he] was soaked, full of feces. Even [his/her] socks were soaked. I am not sure staff are toileting [him/her] every 2 hours which they should be as [s/he] deals with frequent incontinent, not occasional." Surveyor requested Resident 9's hospice record.

On 09/23/2024, at approximately 10:15 AM, Surveyor interviewed hospice Certified Nursing Assistant (CNA) II and CNA JJ. CNA II and CNA

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{N 389}	Continued From page 59 JJ stated Resident 9 is often soaked in urine when they arrive. On 09/23/2024, at approximately 11:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he had replaced Administrator O on 09/20/2024 and was in the process of reviewing all resident records. Administrator EE stated s/he would not accept this kind of oxygen order as it puts the responsibility of determining how much oxygen the resident needs on the caregivers, and they are not nurses. Administrator EE stated s/he was working on re-educating staff on proper resident care. Administrator EE stated there Resident 9 did not have a separate hospice ISP. Resident 9's "Care Plan," undated, documented: "Toileting - Monitor and Cue: Has occasional incontinence and needs more reminding and encouraging with toileting. Staff to attempt to direct [Resident 9] to toilet frequently throughout their shift with a heightened focus before and after meal times. Scheduled: Daily 8:00 AM, 3:00 PM, 11:00 PM." On October 15, 2024, Surveyor reviewed Resident 9's hospice documentation which documented: "09/16/2024 - team assisted patient to bathroom, where [s/he] was incontinent of bowel and bladder." Example 4: Resident 19 On 09/09/2024, at approximately 12:25 PM, Surveyor toured Resident 19's room and observed an oxygen concentrator and oxygen tanks.	{N 389}		

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{N 389}	Continued From page 60 On 09/20/2024, Surveyor reviewed Resident 19's record. Resident 19 moved into the facility, 03/27/2024, with diagnosis including hypertensive heart disease with congestive heart failure. Resident 19's hospice "Routine Standing Orders," dated 07/08/2024, documented: Oxygen orders: Oxygen via nasal cannula or mask at 0 L - 4 L per minute PRN for dyspnea or labored breathing. On 09/23/2024 at 9:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he had replaced Administrator O on 09/20/2024 and was in the process of reviewing all resident records. Administrator EE stated s/he would not accept this kind of oxygen order as it puts the responsibility of determining how much oxygen the resident needs on the caregivers, and they are not nurses.	{N 389}		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices.	N 406		

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Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount.

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not ensure the policy for disposing of outdated medications was implemented to maintain compliance with federal, state, and local standards, laws, or regulations. Outdated prescribed medications were observed in the medication closet for 3 of 3 residents (Resident 9, Resident 16, and Resident 23).

Findings include:

Example 1: Resident 9

On 09/09/2024, at approximately, 11:30 AM, Surveyors observed the medication cart with Caregiver BB. Surveyor found one pack of Bisacodyl suppositories labeled for Resident 9 which read:
"[Resident 9]. Filled: 01/30/2023. Bisacodyl 10 Mg Suppositories. Insert (1) suppository rectally once daily as needed for constipation. Exp: 06/24."
Caregiver BB confirmed the suppositories were expired and stated s/he would put the medication with the other medications that needed to be destroyed. There was not another pack of Bisacodyl available for Resident 9 at that time.

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N 406	Continued From page 62 On 09/19/2024, Surveyor reviewed Resident 9's record which documented: Resident 9 moved into the facility on 09/12/2019. Diagnosis included but are not limited to gastrointestinal hemorrhage, colon polyps, and duodenal ulcer. Active medication orders for September 2024: "Bisacodyl 10 mg suppository- Insert (1) suppository rectally once daily as needed for constipation." Resident 9 admitted to hospice on 10/25/2022. Hospice records document that s/he has a bowel movement less than daily and requires stool softeners. On 09/23/2024 at 9:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he had assigned a staff member to audit med carts at least once a week to ensure expired medications are removed from the cart and properly destroyed. Example 2: Resident 16 On 09/09/2024, at approximately, 12:00 PM, Surveyors observed the medication cart with Caregiver BB. Surveyor observed an opened box of Resident 16's lidocaine patches which read: "Lidocaine pain relief 4%. Apply (1) patch topically to left knee once daily. Remove after twelve hours. Apply (1) patch to left shoulder once daily. Remove after twelve hours. Apply (1) patch to left ribs once daily. Remove after twelve hours. Dispensed date of 12/19/2023." On 09/14/2024, Surveyor reviewed Resident 16's record.	N 406		

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N 406	Continued From page 63 Resident 16 moved into the facility 08/11/2020. Resident 16's August and September 2024 MARs, dated 08/01/2024 to 09/09/2024, did not document that Resident 16 was prescribed lidocaine patches. On 09/23/2024 at 9:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he had assigned a staff member to audit med carts at least once a week to ensure expired medications are removed from the cart and properly destroyed. Administrator EE stated Resident 16's order for lidocaine patches was discontinued in 04/2024. Example 3: Resident 23 On 09/09/2024, at approximately, 12:25 PM, Surveyors observed the medication cart with Caregiver BB. Surveyor observed Resident 23's tube of diclofenac sodium with a dispensed date of 03/23/2022 which read: Apply (2) grams to back/joints four times daily as needed for pain. 17 refills before 03/23/2023." Caregiver BB confirmed the diclofenac sodium was expired and stated s/he would put the medication with the other medications that needed to be destroyed. "After First opening, use the medicinal product for a maximum period of 6 months." (Source: Electronic Medicines Compendium website, Amdeepcha - Diclofenac 1% - Package Leaflet, November 2021, https://www.medicines.org.uk/emc/files/pil.10950.pdf (retrieval date - September 24, 2024).) On 09/23/2024, Surveyor reviewed Resident 23's record.	N 406		

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N 406	Continued From page 64 Resident 23 moved into the facility on 03/26/2020. Resident 23's August and September 2024 MAR, dated 08/01/2024 to 09/23/2024, documented: "Diclofenac Sodium 1% Gel or Voltaren - Apply (2) grams to back/joint(s) four times daily as needed for pain. As needed." On 09/23/2024 at 9:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he had assigned a staff member to audit med carts at least once a week to ensure expired medications are removed from the cart and properly destroyed.	N 406		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN	N 408		

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N 408	Continued From page 65	N 408		

psychotropic medication given.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that 2 of 2 resident's prescribed PRN (as needed) psychotropic medications were documented on the Individualized Service Plan (ISP). The ISP did not include a rationale for use, nor a detailed description of the behaviors, which indicate the need for administration.

This is a repeat deficiency. See Statement of Deficiency (SOD) T56511, dated 04/02/2024.

Resident 17's PRN Lorazepam (psychotropic medication) was not documented in his/her ISP.

Resident 18's PRN Quetiapine Fumarate (psychotropic medication) was not documented in his/her ISP.

Findings include:

Example 1: Resident 17

On 09/09/2024, at approximately 11:40 AM, Surveyors observed the med cart with Med Passer BB. Surveyor observed Resident 17's blister card of PRN Lorazepam with a dispensed date of 07/10/2024.

On 09/14/2024, Surveyor reviewed Resident 17's record.

Resident 17 moved into the facility 04/30/2024.

Resident 17's September 2024 MAR, dated 09/01/2024 to 09/14/2024, documented:

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"Lorazepam - Take (1) tablet orally three times daily as needed for anxiety."
09/01 - Reason - (Not documented)
09/06 - Reason - (Not documented)
09/08 - Reason - (Not documented)
09/14 - Reason - (Not documented)

Resident 17's "Care Plan," undated, documented:
"Medication Management - Receives assistance from staff to administer medication."
"Behavior - [Resident 17] may pack [his/her] bags and wait for [his/her] [spouse] to arrive."

Example 2: Resident 18

On 09/09/2024, at approximately 12:20 PM, Surveyors observed the med cart with Med Passer BB. Surveyor observed Resident 18's blister card of PRN Quetiapine with a dispensed date of 04/09/2024.

On 09/14/2024, Surveyor reviewed Resident 18's record.

Resident 18 moved into the facility 03/13/2024.

Resident 18's September 2024 MAR, dated 09/01/2024 to 09/14/2024, documented:
"Quetiapine Fumarate - Take (1/2) tablet orally once daily as needed for agitation."
09/06 - Reason - (Not documented)
09/08 - Reason - (Not documented)
09/11 - Reason - (Not documented)

Resident 18's "Care Plan," undated, documented:
"Medication Management - Receives assistance from staff to administer medication."
"Behavior - Anxiety. Feel safe and secure in environment to avoid or alleviate episodes of anxiety symptoms."

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N 408	Continued From page 67 "Behavior - Depression. Eliminate or alleviate causes for depression through interactions or medications as prescribed." The Care Plan did not document detailed description of the behaviors his/her PRN Quetiapine would be administered for. Resident 18's "Observations," dated 08/01/2024 to 09/20/2024, did not document any behaviors. On 09/23/2024 at 9:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he had been with the company since 09/20/2024 and s/he would be reviewing all resident records to ensure accuracy and re-educate staff on proper medication administration documentation.	N 408		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure proper documentation on	N 415		

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the Medication Administration Record (MAR) for 3 of 3 residents reviewed.

This is a repeat deficiency. See Statement of Deficiency (SOD) T56511, dated 04/02/2024.

Resident 4's, Resident 16's, and Resident 18's MAR contained the code 'Other' for medication administration with no documented rationale.

Findings include:

On 09/14/2024, Surveyor reviewed Resident 4's, Resident 16's and Resident 18's record.

Example 1: Resident 4

Resident 4's August 2024 Medication Administration Record (MAR) documented:
"Rhopressa. Instill (1) drop into the right eye once daily. Scheduled at 8:00 PM. Start Date: 07/20/2023."
08/27 - Other - No rationale documented
08/28 - Other - No rationale documented
08/30 - Other - No rationale documented
08/31 - Other - No rationale documented

Example 2: Resident 16

Resident 16's September 2024 MAR, dated 09/01/2024 to 09/09/2024, documented:
"Desitin 40% Paste - Apply to affected area(s) of perineal area three times daily. Scheduled at 7:00 AM, 2:00 PM, 8:00 PM. Start Date: 04/17/2024."
09/03 3:54 PM - Other - No rationale listed
09/04 8:09 PM - Other - No rationale listed
09/05 8:35 PM - Other - No rationale listed
09/06 3:29 PM - Other - No rationale listed
09/06 7:52 PM - Other - No rationale listed

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N 415	Continued From page 69 09/08 7:28 PM - Other - No rationale listed 09/09 8:24 AM - Other - No rationale listed Example 3: Resident 18 Resident 18's September 2024 MAR, documented: "Quetiapine Fumarate 25 MG Tab - Take (1) Tablet Orally twice daily, in the morning and at noon for three days." 09/02 9:22 AM - Other - No rationale listed 09/02 11:36 AM - Other - No rationale listed "Quetiapine Fumarate 25 MG Tab - Take 1 Tablet Orally, in the Morning and at Bedtime." 09/09 9:51 AM - Other - No rationale listed On 09/14/2024, at approximately 1:30 PM, Surveyor interviewed Resident Care Manager Y. Resident Care Manager Y stated staff select "Other" when the medication could not be administered and the staff are to document a rationale. On 09/23/2024 at 9:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he had been with the company since 09/20/2024 and s/he would be reviewing all resident records to ensure accuracy and re-educate staff on proper medication administration documentation.	N 415		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the	N 416		

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N 416	Continued From page 70 scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 4 staff members (Med Passer Z, Med Passer BB, Med Passer FF and Med Passer GG) were delegated to administer medications, such as injectables, nebulizers or preparations delivered rectally, by the provider's current registered nurse (RN) within the scope of their license. Findings include: On 10/07/2024, the Department received a concern that med passers were not delegated to pass medications. On 10/07/2024, Surveyor reviewed Resident 3's September 2024 Medication Administration Record which documented Med Passer Z, Med Passer BB, Med Passer FF, and Med Passer GG had administered his/her scheduled Iprat-Albuterol (nebulizer treatment). On 10/07/2024 at 5:15 PM, Surveyor emailed interim Administrator EE requesting the RN delegation Med Passer Z, Med Passer BB, Med Passer FF and Med Passer GG. On 10/08/2024 at 8:26AM, Administrator EE emailed Surveyor and stated s/he would reach out to Administrator O to locate the RN delegation paperwork regarding staff. As of 10/14/2024 at 5:00 PM, Surveyor did not receive any documentation.	N 416		

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N 425	Continued From page 71	N 425		
N 425	83.38(1)(a) Personal care. 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: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 2 of 2 residents received adequate services to meet the needs of the resident. This is a repeat deficiency. See Statement of Deficiency (SOD) 2U5R12, dated 06/01/2023. Resident 3 did not receive a shower due to unavailability of his/her Hoyer sling. Resident 3 did not receive adequate assistance with peri care. Resident 15 did not receive routine assistance with incontinence care. Findings include:	N 425		

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On 08/01/2024, 10/01/2024 and 10/07/2024, the Department received concerns alleging residents did not receive adequate care.

Example 1: Resident 3

On 09/18/2024, at approximately 1:15 PM, Surveyor interviewed hospice Registered Nurse (RN) CC. RN CC stated it was a common problem with the hospice residents at this location; the residents did not receive proper peri care and their slings were always missing. RN CC stated, "Sometimes staff can find them in other resident rooms, but usually when you ask a staff member, they do not know where the slings are or knew the resident required a sling." Surveyor requested Resident 3's hospice documentation.

On 09/23/2024, at approximately 10:15 AM, Surveyor interviewed hospice Certified Nursing Assistant (CNA) II and CNA JJ. CNA II and CNA JJ stated it was a common problem with the hospice residents at this location; the residents did not receive proper peri care and their slings were always missing.

On 09/23/2024, at approximately 11:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he had been with the company since 09/20/2024 and was working on re-educating staff on proper resident care.

On October 15, 2024, Surveyor reviewed Resident 3's hospice documentation which documented:

"09/16/2024 - Patient getting a bed bath today. CNA's (certified nursing assistants) unable to give a shower since sling is currently being washed."

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"09/20/2024 - Patients private area was inflamed and irritated had [Hospice Register Nurse CC] come look along with dried on feces."
"09/23/2024 - Patient had dried stool on buttocks and scrotum ... Patient was also saturated in urine through [his/her] pants ... Blanchable red area across majority of buttocks, posterior thighs and scrotum. Scrotum appears raw and painful. ... Redness noted in groin that has been ongoing. ... Writer collaborated with [hospice health aides] as they reported patient did not have supplies available in the room, such as wipes and barrier cream. ... Writer spoke to [interim Administrator EE] regarding ... patient not having supplies in [his/her] room. ... Writer informed [Administrator EE] of patient's redness to buttocks, scrotum and posterior thigh, with concern that an open area will become present. ..."

Example 2: Resident 15

On 09/09/2024, from approximately 9:00 AM to 11:00 AM, Surveyors toured the facility and detected a urine like scent emanating from Resident 15's room. At approximately 10:10 AM, Surveyors entered Resident 15's room and observed a bathroom garbage can which contained soiled Depends.

On 09/09/2024, at approximately 1:15 PM, Surveyor interviewed Resident Care Manager Y. Resident Care Manager Y stated the provider utilized a lot of agency staff and could not confirm if all staff understood what cares each resident required.

Resident 15 admitted to the facility, 02/06/2024, with diagnosis including dementia without behavioral disturbance.

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Resident 15's "Care Plan," undated, documented: "Toileting Program - Full Assist: Hands on assistance and/or cuing as needed to maintain Q 2 (every 2) hr (hours) while awake and 2x (2 times) on NOC. Remove soiled products immediately.

On 09/18/2024, at approximately 1:15 PM, Surveyor interviewed hospice Registered Nurse (RN) CC. RN CC explained, "[Resident 15] does not realize when s/he is voiding. [S/he] has chronic discoloration to [his/her] legs due to this. Staff really need to ensure [s/he] is toileted at least every two hours while [s/he] is awake. [S/he] is often soiled when I arrive to provide cares." Surveyor requested Resident 15's hospice documentation.

On 09/23/2024, at approximately 10:15 AM, Surveyor interviewed hospice Certified Nursing Assistant (CNA) II and CNA JJ. CNA II and CNA JJ explained that Resident 15 suffered from extreme incontinence and did not feel staff adequately maintained his/her toileting schedule. As Surveyor interviewed CNA II and CNA JJ, Surveyor observed 3 staff members congregated at the end of the hall, laughing and on their personal phones. This occurred for over 30 minutes.

On 10/15/2024, Surveyor reviewed Resident 15's hospice documentation which documented: "09/02/2024 - Writer provided incontinence cares for patient and changed the chux pad on [his/her] chair, as it was soiled. Patient was taken to the bathroom with no further void or BM (bowel movement). Writer assisted patient in changing clothes and walked patient back to recliner." "09/09/2024 - Pt incontinence is becoming more [his/her] baseline in the last month. Care team

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N 425	Continued From page 75 assisted pt in changing [his/her] pants and socks. ... As patient was ambulating in hallway, [s/he] was incontinent of urine. [Hospice] team assisted patient back to room where incontinence cares were provided and new clothes put on."	N 425		
{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 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.	{N 431}		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 3 residents reviewed received appropriate health monitoring to meet his/her needs.

This is a repeat deficiency. See Statement of Deficiency (SOD) YSHR11, dated 06/06/2024.

Resident 11's record did not document weights, blood pressure readings, pulse readings, temperatures, and/or respirations as documented in his/her Service Plan Task.

Resident 19's blood pressure and weights were to be obtained daily which was not completed.

Findings include:

On 08/01/2024 and 10/01/2024, the Department received a concern alleging residents are not receiving adequate care.

Example 1: Resident 11

On 09/09/2024, at approximately 9:30 AM, Surveyor interviewed Resident Care Manager (RCM) Y. RCM Y stated that Resident 11 had been hospitalized due to a fall and had not returned to the facility, yet.

On 09/10/2024, Surveyor reviewed Resident 11's record.

Resident 11 moved into the facility, 06/22/2022, with diagnoses including generalized weakness,

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acute respiratory failure with hypoxia and hypercapnia (imbalance of oxygen dioxide in the body), cerebral vascular accident and hyperlipidemia (high cholesterol).

Resident 11's "Observations," dated 07/01/2024 to 09/09/2024, documented:
"08/17/2024 - Incident: Went into room to deliver room tray and found resident lying on the floor in front of wheelchair. Stated [s/he] fell asleep in [his/her] wheelchair and when [s/he] woke up [s/he] tried to get up and was dizzy and fell. Pain Level = 8. Pulseox (pulse oximeter - measures how much oxygen is in the bloodstream) = 91 (A normal pulse oximeter reading for your oxygen saturation level is between 95% and 100%). Transferred to hospital."
"08/19/2024 - Resident was admitted to [hospital] yesterday, was sent in for a fall but was admitted for toxic resp (respiratory) failure and is on 5L (liters) of O2 (oxygen). [S/he] is now a 2 max assist with transfers and in bed. [S/he] will be staying a couple more days at [hospital] and they will call back when [s/he] is ready to be discharged."

The Observations did not document signs and symptoms of respiratory distress prior to this incident.

Resident 11's "Care Plan," undated, documented:
"Vitals - 01/31/2023 - Per physicians order the med passer will weigh [Resident 11] twice per week and record [his/her] weight. If [Resident 11] displays any weight gain the med passer will notify the director who will evaluate and notify the MD (medical doctor)."

Resident 11's "Service Plan Task" documented:
"Vital Signs Review - Review of weight, blood

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pressure, pulse, temp (temperature) and respirations. Investigate and report discrepancies of 5# (pound) or fluctuations in BP (blood pressure) or elevated temperatures. Start Date: 06/21/2022."

Resident 11's August 2024 "Medication Administration Record (MAR)," dated 08/01/2024 to 08/17/2024, did not document any weights, blood pressure readings, pulse readings, temperatures, and/or respirations.

On 09/09/2024, at approximately 1:00 PM, Surveyor interviewed Administrator O. Surveyor stated Resident 11's Incident Report stated s/he had sustained a fall and was hospitalized due to pain. The Observation notes stated s/he was hospitalized due to toxic respiratory failure. Administrator O stated s/he would need to review the documentation and discuss the concern with staff to determine why Resident 11 had been sent out after his/her unwitnessed fall. Administrator O did not know when Resident 11 would return from the hospital and was unsure if s/he was still hospitalized or had been transferred to another facility for rehabilitation. Surveyor reviewed Resident 11's Observations with Administrator O and asked if staff documented signs of a possible change of condition somewhere else, since the Observations did not have any documentation defining Resident 11 was experiencing signs of respiratory failure. Administrator O stated s/he would follow up with staff as each building s/he oversaw completed documentation differently.

"The respiratory control center responds to altered levels of CO2 (carbon dioxide) and O2 (oxygen) by changing the respiratory rate and pattern. Interestingly, the response to hypoxia differs from the response to hypercapnia. Hypoxia

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induces a breathing pattern of rapid and shallow breaths with a relatively higher increase in respiratory rate than tidal volume. The aim is to decrease the cost of breathing by avoiding the need to overcome the lungs' higher elastance at high volumes. In simple terms, breathing with high tidal volumes requires more negative pressure generation in the intra-pleural space and, thus, more oxygen utilization by respiratory muscles, especially in an already hypoxic patient. In contrast, hypercapnia triggers a breathing pattern of deep and slow breaths with a relatively more significant increase in tidal volume than respiratory rate. This pattern aims to limit dead space ventilation and optimize carbon dioxide elimination." (Source: National Library of Medicine (NIH) website, Physiology, Respiratory Drive, June 5, 2023, https://www.ncbi.nlm.nih.gov/books/NBK482414/ (retrieval date - October 01, 2024).)

On 09/23/2024, at approximately 9:30 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated Licensee A had made the decision to replace Administrator O and s/he had started with the provider on 09/20/2024. Administrator EE reviewed Resident 11's record and determined that signs and symptoms of possible respiratory failure had not been documented or that any vitals had been documented.

Example 2: Resident 19

On 09/23/2024, Surveyor reviewed Resident 19's record.

Resident 19 moved into the facility, 03/27/2024, with diagnoses including hypertension and chronic diastolic heart failure.

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{N 431}	Continued From page 80 Resident 19's "Care Plan," undated, documented: "Daily Weights - Obtain daily weights for resident and fax PCP (primary care physician) every Friday." "Vitals - Blood Pressure - Obtain blood pressure daily and fax to PCP every Friday. Resident takes Metoprolol 2x's daily. Blood pressure and pulse readings must be obtained. Take daily blood pressure and pulse prior to administration of Metoprolol." Resident 19's August and September 2024, dated 08/01/2024 to 09/23/2024, Medication Administration Record (MAR) documented: "Metoprolol succ (succinate) ER (extended release) 25 MG (milligram) tab (tablet) - Take (3) tablets orally twice daily. Start Date: 06/10/2024." The MARs did not document any blood pressures and only documented weights on 09/02 and 09/06. On 09/23/2024, at approximately 9:30 AM, Surveyor reviewed the concern with interim Administrator EE. Administrator EE stated when an individual is on Metoprolol, it was common practice that blood pressures had to be tracked. Administrator EE stated s/he had only been with the company since 09/20/2024 and could not answer why Resident 19's blood pressure and weights were not monitored as outlined in his/her Care Plan.	{N 431}		
N 448	83.41(2)(a) Nutrition: diet. Diets. 1. The CBRF shall provide each resident with palatable food that meets the recommended dietary allowance based on current dietary	N 448		

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guidelines for Americans and any special dietary needs of each resident. 2. The CBRF shall provide a therapeutic diet as ordered by a resident ' s physician.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure residents received a diet specific to their diagnosis.

Resident 5 was prescribed a mechanical soft diet which s/he did not receive.
Resident 9 was prescribed a thickened liquid diet (medical dietary adjustment that involves drinking liquids with a thicker consistency to help prevent choking and protect the airway).
which s/he did not receive.

Findings include:

On 09/09/2024, at approximately 11:15 AM, Surveyors interviewed Cook HH. Cook HH explained that s/he was new to the facility, had been there about two weeks, and did not have a menu to work from. S/he was creating a menu as s/he went, working with the ingredients that were available.

Example 1: Resident 5

On 09/18/2024, at approximately 1:15 PM, Surveyor interviewed hospice Registered Nurse (RN) CC. RN CC voiced concerns regarding Resident 5 not receiving his/her prescribed mechanical soft diet. RN CC stated, "Every time I am in here, [s/he] is being provided the regular menu. Thankfully [s/he] has not choked. I have

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re-educated the staff, but it does not seem to change the outcome."

On 09/19/2024, at approximately 5:00 PM, Surveyor observed Resident 5 during the evening meal. Resident 5 was served barbecue pulled beef on a bun and potato chips.

On 09/19/2024, at approximately 5:10 PM, Surveyor went into the kitchen and interviewed Caregiver KK. Caregiver KK stated that each resident had a "Diet Card." Surveyor and Caregiver KK started to look through the cards. Resident 5's card stated, in large print, "Mech (mechanical) Soft Meats Vegs (vegetables)." Surveyor asked if staff reviewed these cards prior to plating the resident's food. Caregiver KK stated, "Most of us know what diet the residents need."

On 09/20/2024, Surveyor reviewed Resident 5's record.

Resident 5 moved into the facility on 04/25/2023 and was on hospice.

Resident 5's "Service Plan" that staff utilized to provide adequate cares documented:
"Eating - Assist - Mechanical Soft. As of 07/10/2024 Resident has been moved to a Mechanical Soft Diet. Resident may require assistance at times. Resident is still on Thin Liquids."

On 09/23/2024 at 9:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he had been with the company since 09/20/2024 and s/he would be reviewing all resident records to ensure accuracy and that staff were re-educated on resident cares.

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Administrator EE stated barbecue pulled beef would not be considered a mechanical soft diet.

On 09/25/2024, Surveyor reviewed Resident 5's hospice documentation which documented: "08/23/2024 - [Caregiver K] reports patient has been doing well with meals and there has not been a concern with difficulty swallowing. ... Writer walked over to dining room, where patient was eating lunch. [S/he] was eating a hamburger and fries ... Writer touched based with [Caregiver K] regarding patient's diet, as [s/he] is supposed to be a mechanical soft diet."

On 10/11/2024, at approximately 12:30 PM, Surveyor observed Resident 9 eating his/her noon meal. The menu read pork chops, au gratin potatoes, and yellow squash. Surveyor noted Resident 9's pork chop was not a mechanical soft diet.

"A mechanical soft diet is a texture-modified diet that restricts foods that are difficult to chew or swallow. It's considered Level 2 of the National Dysphagia Diet in the United States. Foods can be pureed, finely chopped, blended, or ground to make them smaller, softer, and easier to chew. It differs from a pureed diet, which includes foods that require no chewing." (Source: Healthline website, What is a mechanical soft diet?, October 07, 2021, https://www.healthline.com/nutrition/mechanical-soft-diet#bottom-line (retrieval date - October 13, 2024).)

Example 2: Resident 9

On 09/09/2024 at 11:18 AM, Surveyors observed a glass sitting on a table in the dining room that had a white powder like substance in it. There

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was no one sitting at the table at that time. Writer asked Caregiver BB if s/he knew what was in the cup and s/he stated it was most likely Resident 9's Thick-It.

On 09/09/2024 at 3:15 PM, Surveyor entered Resident 9's room. S/he was napping, and Surveyor observed a cup with a lid and straw which contained water on his/her bedside table. Surveyor assessed the liquid in the cup and determined it was thin liquid as it was normal water like consistency. Surveyor had been told resident should receive thickened liquids. Surveyor carried the cup into the kitchen and interviewed Cook HH. Cook HH stated most people knew Resident 9 required thickened liquids, and it was probably one of the facility's agency caregivers who provided the thin liquid water.

On 09/19/2024, Surveyor reviewed Resident 9's record.

Resident 9 moved into the facility 09/12/2019. Resident 9's care plan did not document that s/he was on a thickened liquid diet.

On 09/19/2024, Surveyor requested and reviewed Resident 9's hospice records which documented: 07/12/2024 - Nutrition: Diet type - regular, thickened liquid

On 09/23/2024 at 9:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he had been with the company since 09/20/2024 and s/he would be reviewing all resident records to ensure accuracy and that staff were re-educated on resident cares.

Cross Reference: N0450 DHS 83.41(2)(c)

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N 448	Continued From page 85 Nutrition: Menus Cross Reference: N0452 DHS 83.41(3)(b) Food Safety	N 448		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation, record review and interview, it was determined that the provider did not have planned or posted menus readily available to the residents. Findings include: On 09/09/2024, at approximately 11:15 AM, Surveyors interviewed Cook HH. Cook HH explained that s/he was new to the facility, had been there about two weeks, and did not have a menu to work from. S/he was creating a menu as s/he went, working with the ingredients that were available. On 09/18/2024, at approximately 1:15 PM, Surveyor interviewed hospice Registered Nurse (RN) CC. RN CC voiced concerns regarding residents receiving prescribed therapeutic diets. On Monday, 09/23/2024, from approximately 9:00 AM to 11:30 AM, Surveyor toured the facility and	N 450		

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N 450	Continued From page 86 observed a whiteboard where the daily menu was documented. The whiteboard was blank. Surveyor observed a sheet of paper hanging next to the whiteboard that was undated which appeared to be a weekly menu. The paper listed menu items for Thursday, Friday, Saturday, and Sunday. Surveyor had been onsite Thursday 09/19/2024 during the evening meal. Residents were served barbecue shredded beef and potato chips. The current menu listed grilled cheese and tomato soup. On 09/23/2024 at 9:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he would discuss the concern with the dietary staff.	N 450		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving.	N 452		

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This Rule is not met as evidenced by:
Based on observation and interview, the hot food served to residents was not maintained at 140°F (degrees Fahrenheit).

Findings include:

On 09/18/2024, at approximately 1:15 PM, Surveyor interviewed Hospice Registered Nurse (RN) CC. RN CC had expressed concerns with therapeutic diets residents were being served.

On 09/19/2024, at approximately 5:00 PM, Surveyor observed the serving of the evening meal.

On 09/19/2024, at approximately 5:10 PM, Surveyor toured the kitchen and observed 6 prepared plates of barbecue shredded beef and potato chips sitting on a cart.

On 09/19/2024, at approximately 5:13 PM, staff assisted Resident 13 to the dining table and went to the kitchen to retrieve a plate of food for him/her.

On 09/19/2024, at approximately 5:17 PM, staff walked a plate of food to Resident 16, whose room is at the end of the hall to the left. Surveyor noted the food was not covered.

On 09/19/2024, at approximately 5:19 PM, staff walked a plate of food to Resident 1, whose room is in the middle of the hall to the right. Surveyor noted the food was not covered.

On 09/19/2024, at approximately 5:23 PM, Surveyor walked back into the kitchen and

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N 452	Continued From page 88 observed that there was only one plate of food left on the cart. Surveyor temped the barbecue shredded beef which temped at 106 °F. "Bacteria grow rapidly between 41° F and 135° F. This range is known as the temperature danger zone. Bacteria grow even more rapidly from 70° F to 125° F. Bacteria need time to grow. The more time bacteria spends in the temperature danger zone, the more opportunity they have to grow to unsafe levels." "Hold hot food at an internal temperature of 135°F or higher. Hold cold food at an internal temperature of 41°F or lower." "If you primarily serve a high-risk population, do not hold TCS food (food requiring time and temperature control for safety) without temperature control." (Servsafe Coursebook - 7th Edition, 2017, p 2.5 and 9.2) On 09/23/2024 at 9:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he would discuss the concern with the dietary staff and provide re-education.	N 452		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure a living environment that was safe, clean, comfortable, and homelike.	N 481		

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N 481	Continued From page 89 This is a repeat deficiency. See Statement of Deficiency (SOD) 2U5R12, dated 06/01/2023, and T56511, dated 04/02/2024. Findings include: On 09/09/2024, from approximately 9:00 AM to 3:00 PM, Surveyors toured the facility and observed: 1.) Resident 12's carpeting leading from the bathroom door to his/her bed displayed brown circular markings that appeared to be caused by his/her wheelchair. 2.) Toilet seat cover in the bathroom next to the private dining room displayed brown markings around the toilet seat that appeared to be feces. The flooring appeared to have a dust buildup. The sink faucet had a buildup of what appeared to be dirt and soap scum. 3.) The community bathroom, at the end of the hall to the left of the facility entrance, had a toilet seat cover that displayed brown markings around the toilet seat that appeared to be feces. The available toweling was a large roll of paper toweling meant for the dispenser sitting on the bathroom vanity where it could be contaminated while individuals washed their hands. The garbage can was overflowing with used paper toweling and fast-food wrappers. 4.) Resident 13's room did not have toweling available in his/her bathroom. 5.) The large television in the common area, without any sound, had an error code displaying across the television screen which blocked the	N 481		

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N 481	Continued From page 90	N 481		

television program being displayed, and the glare from the large picture windows reflected onto the television which distorted the television program being displayed. Surveyor observed 4 residents sitting in the area.

On 09/09/2024, at approximately 3:30 PM, Surveyor interviewed Administrator O. Administrator O stated s/he would address the concerns with staff.

On 09/19/2024, at approximately 4:45 PM, Surveyor observed what appeared to be a broken recliner chair sitting in the common area at the end of the left wing. Surveyor noted residents ambulated independently throughout the building and could have utilized the chair with the possibility of being injured.

On 09/23/2024, at approximately 10:15 AM, Surveyor interviewed hospice Certified Nursing Assistant (CNA) II and CNA JJ. CNA II and CNA JJ stated there had been issues with water temperatures. Resident 9 had been bathed in a vacant room because the water in his/her bathroom could not be regulated. Surveyor temped Resident 9's water which temped at approximately 91 degrees Fahrenheit. On 09/23/2024, at approximately 1:15 PM, Surveyor interviewed Resident Care Manager Y who stated s/he was aware that Resident 9 was bathed in a vacant room due to concerns of his/her water temperature.

On 09/23/2024, at approximately 10:25 AM, Surveyor observed hospice Certified Nursing Assistant (CNA) II come out of Resident 9's room. CNA II stated, "[His/her] garbage can has emesis (vomit) in it and of course there is no plastic liner in the garbage can."

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N 481	Continued From page 91 On 09/23/2024, at approximately 10:55 AM, Surveyor observed Resident 19's room. Resident 19's carpeting had an approximately 12 inch by 4 inch and a six inch circular red pattern which appeared to be cause by something spilled. On 09/23/2024 at 11:30 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he had only been with the company since 09/20/2024 and would follow up on the identified concerns.	N 481		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on interview and observation, the provider did not ensure that all rooms are clean and free from odor. This is a repeat deficiency. See Statement of Deficiency (SOD) GNOK12, dated 07/20/2022. Findings include: On 09/09/2024, from approximately 9:00 AM to 3:00 PM, Surveyors toured the facility and observed: 1.) Resident 12's room had a strong urine like odor in the bathroom. The grout of the tile flooring around the toilet was a brown color. Resident 12's laundry basket was full of soiled clothing that smelled of incontinence.	N 489		

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N 489	Continued From page 92 2.) Resident 14's room had a strong urine like odor emanating throughout. 3.) Resident 15's room had a strong urine like odor emanating throughout. His/her bathroom garbage can contained soiled Depends. There was a used disposable glove laying on the bathroom floor. The bathroom floor appeared sticky when walking across. 4.) Resident 16's bathroom emanated a urine like odor. There were soiled clothing items stacked on top of his/her shower chair. There was a box of oranges that had a white mold like substance sitting on the bedroom floor. On 09/09/2024, at approximately 2:00 PM, Surveyors interviewed Resident Care Manager Y. Resident Care Manager Y stated there had been concerns with housekeeping as staff did not pull soiled clothing out of the rooms and the provider was working on hiring additional staff. On 09/09/2024, at approximately 3:30 PM, Surveyor interviewed Administrator O. Administrator O stated s/he would address the concerns with staff. On 09/23/2024, at approximately 11:10 AM, Surveyor walked past Resident 1's room and detected a urine like scent emanating from his/her bedroom. On 09/23/2024, at approximately 11:15 AM, Surveyor observed Med Passer BB come out of Resident 22's room; s/he had just finished cleaning the bathroom. Surveyor walked into the bathroom and the bathroom still smelled strongly of incontinence.	N 489		

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N 489	Continued From page 93 On 09/23/2024, at approximately 11:20 AM, Surveyor observed Resident 3's bathroom. Resident 3's bathroom smelled strongly of a bowel like scent. There were rolled up toilet paper balls on the floor and behind the toilet. There was what appeared to be waterlogged toilet paper in the shower area. His/her laundry basket was overflowing with soiled clothing. Resident 3's bathroom had a urine like scent to it. On 09/23/2024 at 11:30 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated s/he was in the process of hiring additional staff to address these concerns.	N 489		
Z 010	50.065(2)(bb) DETERMINE FINAL DISPOSITION OF CHARGE If information obtained under par. (am) or (b) indicates a charge of a serious crime, but does not completely and clearly indicate the disposition of the charge or the conviction, the department or entity shall make every reasonable effort to contact the clerk of courts to determine the final disposition of the charge. If a background information form under sub. (6) (a) or (am) indicates a charge or a conviction of a serious crime, but information obtained under 011 par. (am) or (b) does not indicate such a charge, the department or entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and the final disposition of the complaint. If information obtained under par. (am) or (b), a background information form under sub, (6) (a) or (am) or any other information indicates a	Z 010		

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Z 010	Continued From page 94	Z 010		

conviction of a violation of s. 940.19 (1), 940.195, 940.20, 941.30, 942.08, 947.01, or 947.013 obtained not more than 5 years before the date on which that information was obtained, the department or the entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction relating to that violation.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not make every reasonable effort to obtain a copy of the criminal complaint and judgment of conviction related to Caregiver AA's violation of 947.01(1) Disorderly Conduct on 10/07/2019.

This is a repeat deficiency. See Statement of Deficiency (SOD) GRGR11, dated 06/02/2022.

Findings include:

The provider is licensed to serve up to 40 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, terminally ill, and physically disabled.

On 09/09/2024, Surveyor reviewed Caregiver AA's record.

Caregiver AA was hired on 08/01/2024. Caregiver AA's Department of Justice Criminal History Report, dated 07/31/2024, included a charge of 947.01(1) Disorderly Conduct charged on 10/07/2019.

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Z 010	Continued From page 95 On 09/09/2024, at approximately 2:30 PM, Surveyor asked Administrator O if the provider had the criminal complaint and judgement of conviction, or documentation of attempts to receive the criminal complaint, for Caregiver AA's 10/07/2019 charge of disorderly conduct. Administrator O stated it is company policy to request and try to obtain a criminal complaint and judgement of conviction from the clerk of courts office and the former administrator would have made attempts to request information on the charge, but Administrator O did not have further documentation to indicate this was done. As of 09/14/2024 at 5:00 PM, Surveyor did not receive any additional documentation. Cross Reference: N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment	Z 010		
Y3234	50.09(1)(e) Treatment (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: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact.	Y3234		

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Y3234	Continued From page 96	Y3234		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 2 resident were treated with courtesy, respect and full recognition of the resident's dignity and individuality.

Resident 10 and Resident 21 were involved in a consensual sexual relationship and staff were monitoring them in a manner that resulted in their dignity and individuality being violated.

Findings include:

On 08/07/2024, the Department received a concern that two residents were acting sexually inappropriate.

On 09/09/2024, at approximately 11:00 AM, Surveyor interviewed Resident Care Manager (RCM) Y. RCM Y stated there were concerns among staff that Resident 10 and Resident 21 were engaging in a sexual relationship. RCM Y stated staff were to redirect the two residents if they were thought to be headed together to an individual's room.

On 09/09/2024, Surveyors requested Resident 10's and Resident 21's records.

On 09/19/2024, at approximately 5:40 PM, Surveyor interviewed agency staff Caregiver DD. Caregiver DD stated s/he had been informed by staff that Resident 10 and Resident 21 were not to go into each other's room or be left alone together.

On 09/20/2024, Surveyor reviewed Resident 10's and Resident 21's records.

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Y3234	Continued From page 97 Resident 10 moved into the facility 02/23/2024 and is his/her own person. Resident 10's "Care Plan," undated, documented: "Cognitive Deficits: (No Comments documented)" "Relationships: [Resident 10] has formed a relationship with another resident. Staff to ensure that both parties can consent to any physical relationship cognitively. Staff to provide supervision and redirection if both parties are unable to consent." Resident 10's "Observations" documented: "08/27/2024 written by Caregiver K - Resident was caught kissing another resident in the common area. Both residents were told that it is inappropriate and that they need to keep their hands to themselves." "08/27/2024 written by Caregiver K - Incident Report (Behavior - Sexual) created for [Resident 10]." Resident 21 moved into the facility 07/11/2024 and is his/her own person. Resident 21's "60 Day Assessment" documented: "Cognition/Emotion/Behavior: Resident does experience anxiety from time to time." "Relationships: [Resident 21] has formed a relationship with another resident. Staff to ensure that both parties can consent to any physical relationship cognitively. Staff to provide supervision and redirection if both parties are unable to consent." Resident 21's "Observations" documented: "08/18/2024 written by Med Passer BB - Caregivers found the resident in [Resident 21's] bed. When the caregiver opened the door they	Y3234		

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Y3234	Continued From page 98 quickly separated. The caregiver had the resident go back to [his/her] room." "08/27/2024 written by Caregiver K - Resident was caught kissing another resident in the common area. Both residents were told that it is inappropriate and that they need to keep their hands to themselves." On 09/23/2024 at 9:00 AM, Surveyor interviewed interim Administrator EE. Administrator EE stated the Ombudsman would be providing resident rights training.	Y3234		