STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011954	A. BUILDING: _____ B. WING _____	R-C 08/16/2023

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CARE PARTNERS STEVENS POINT 2	3349 BUILDING B WHITING AVENUE STEVENS POINT, WI 54481

(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 08/03/2023 and 08/07/2023, Surveyor conducted onsite visits at Care Partners Stevens Point 2 to investigate a complaint, review a self-report, complete a survey and conduct a verification visit. Additional information was received through 08/16/2023. Six (6) of the 7 previous deficiencies were corrected. The complaint was substantiated and a total of 4 new deficiencies were identified. Census: 8 Under statutory provisions of WI Stat. Ch. 50 a $200 revisit fee is being assessed.	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.	N 158		

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

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N 158	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, after receiving an allegation of abuse the provider did not take steps to immediately protect the safety of all residents or conduct a thorough investigation into the allegations to determine if misconduct occurred that required reporting to the Department within 7 days. Between approximately 04/01/2023 and 04/25/2023, Administrator A and Assistant Administrator D had knowledge Caregiver C was "a bully" and was treating residents disrespectfully. In addition, Resident 1 made a specific, written allegation of verbal/mental abuse on 04/23/2023. The provider did not take immediate steps to ensure resident safety or investigate the concerns. On 04/25/2023 at approximately 5:00 PM, Administrator A was informed Caregiver C yelled at Resident 2, refused Resident 2 food during a time when s/he had low blood sugar and confined Resident 2 to his/her room. Administrator A did not ensure immediate steps were taken to protect Resident 2 or other residents, Caregiver C was allowed to finish his/her shift, and an investigation was not started until the next day. While investigating the 04/25/2023 incident, Administrator A received allegations of abuse against a second caregiver. Resident 1 alleged s/he also did not feel safe when Caregiver E worked. Resident 1 described verbal abuse and being made to go to bed at 5:00 PM. Administrator A did not conduct an investigation into the allegations against Caregiver E to determine if the incident warranted misconduct reporting to the Office of Caregiver Quality.	N 158		

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N 158	Continued From page 2 This is a repeat deficiency being cited for the 2nd time. See Statement of Deficiency YU9Z11, dated 02/25/2021. Findings include: The provider is licensed to serve up to 16 non-ambulatory residents from the following client groups; irreversible dementia/Alzheimer's, terminally ill, physically disabled or advanced age. The Department received a complaint that caregivers are abusive and residents are afraid of them. The Department received a self-report from the provider on 04/26/2023 which included allegations of misconduct against Caregiver C and Caregiver E. SELF-REPORT The self-report included the following documents: Written statement by Resident 1: 04/23/2023 - "The reason I stay in my room is [Caregiver C] [s/he]'s mean & hateful calls me names & sarcastic yells at residents any thing or say or do wrong [s/he] picks on me I pay $904 per month to stay in room. Sometimes [s/he] screams at me & I'm afraid. I go to my room. I can hear [him/her] screaming at clients [S/he]'s mean and cruel...(signed) [Resident 1] Sunday 4 23 23" [sic all] Written statement by Assistant Administrator D On 4/25/2023 at 4:51 PM, s/he received a call from Caregiver C who admitted putting Resident 2 in his/her room before s/he had finished dinner	N 158		

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and with knowledge Resident 2 had low blood sugar. During the call Assistant Administrator D heard Caregiver C yelling at Resident 2. Assistant Administrator D told Caregiver C that Caregiver E should recheck Resident 2's blood sugar and to be sure to record it. Assistant Administrator D's only other documented response was to call Administrator A to report the situation.

Second written statement by Resident 1:
04/26/2023 - "I...heard [Resident 2] say [s/he] wanted [his/her] food back, and [Caregiver C] screamed at [Resident 2]...I do not feel safe at care partners when [Caregiver C] and [Caregiver E] are here. Being yelled at and, made to go to bed at 5pm, and Being threatened, afraid to ask for med...(signed) [Resident 1] 4/26/23" [sic-all]

Investigation Summary dated 04/27/2023, authored by Administrator A:
Caregiver C violated Resident 2's rights on 04/25/2023 at 4:51 PM by refusing food and confining him/her to his/her room.
"I did ask all residents if they feel safe here at Care Partners and they all stated that the [sic] don't like [Caregiver C] because [s/he] isn't nice to them...Residents are scared of [him/her], they stated [s/he] is demeaning and rude, rough with them."
Caregiver C was suspended and terminated (dates not provided)

The self-report documentation did not include:
Information about the immediate steps taken to protect Resident 1 and other residents between 04/23/2023 (Resident 1's 1st statement) and 04/25/2023 (abuse against Resident 2.)
Information about the immediate steps taken to protect Resident 2 and all other residents between 04/25/2023 at 4:51 PM and 04/26/2023

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when Administrator A began his/her investigation. Evidence an investigation was completed after receiving misconduct allegations against Caregiver E on 04/26/2023 (Resident 1's 2nd statement.)

The Department sent an email to the provider on 05/11/2023 and asked clarifying questions about the self-report. Administrator A replied on 05/11/2023:

Question: Did Caregiver C work 04/23 and 04/24? Response: "[S/he] worked the 23rd but not the 24." [sic]
Question: What time was Caregiver C suspended and did s/he finish 2nd shift on 04/25. Response: "Yes, [s/he] did finish [his/her] shift on 4/25."
Question: Was Resident 1's 4/26 statement about Caregiver E investigated? Response: "[Resident 1] doesn't have a problem with [Caregiver E], only when [Caregiver C] was around."

INTERVIEWS

Assistant Administrator D - on 08/03/2023 at 11:04 AM, Surveyor interviewed Assistant Administrator D who stated:
During the 04/25/2023 phone call from Caregiver C s/he could "hear [Caregiver C] screaming at [Resident 2]...it blew my mind."
Caregiver E was the only other staff working at the time. Surveyor asked what Caregiver E was doing during the incident and s/he replied, "Nothing. That was something that really bothers me. If I'm doing something (wrong) I would expect my peer to tell me to calm down and step out. That didn't happen with them two." [sic - all]
In response to the call s/he told Caregiver C to bring Resident 2 out of his/her room, allow him/her to finish eating and recheck blood sugar

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again to see if it was back in normal ranges. S/he also immediately called Administrator A to report the incident and said, "I did make it clear to [Administrator A] [Caregiver C] was screaming at the resident while I was on the phone with [him/her] and [s/he] had put Resident 2] in [his/her] room and hadn't let [him/her] finish dinner...(telling Resident 2) to calm down and grow up."
No management staff reported to the facility and Caregivers C and E completed 2nd shift alone.

Assistant Administrator D described concerns about Caregiver C's treatment of residents in the 3-4 weeks preceding the 04/25/2023 incident:
"I had my suspicions [s/he] was being mean to the [residents]. Anytime [Caregiver C] walked in the building every one of the residents would scatter (including) [Resident 3 and Resident 4]. [Resident 4] would even tremble...Me and a couple of the other (caregivers) were talking and keeping an eye on [Caregiver C]. It wasn't just me that had a sense something was going on...the last few weeks [s/he] was here it seemed like [s/he] was escalating...That's where I'm kinda bad, I did tell [Administrator A] that residents are scared of [Caregiver C] and there's gotta [sic] be a reason why, but I let it go at that instead of being more specific..."
During that time, "[Resident 2] said [Caregiver C] was being mean and verbally abusive" and Assistant Administrator D observed Caregiver C tell Resident 2, "Shut the damn (call) light off. You don't need anything right now."
"[Resident 1] said (to me) [s/he] just wasn't going to come out of [his/her] room because [s/he] didn't want to be bullied...When I would see [Resident 1] s/he was all smiles and laughs and jokes and I'm hearing when I leave (at the end of 1st shift) [s/he] locks [him/herself] in [his/her]

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room."
Resident 1 wrote the 04/23/2023 statement because "[Resident 1] wanted something recorded so that way if something did happen, [s/he] would be protected." The statement was received by Assistant Administrator D on Sunday 04/23/2023 and s/he gave it to Administrator A on Monday 04/24/2023. (Surveyor note: Caregiver C worked 2nd shift on 04/23 according to the April 2023 schedule provided by Administrator A and the aforementioned 05/11/2023 email.)

Resident 1 - on 08/03/2023 at 12:27 PM, Surveyor interviewed Resident 1 who stated:
For at least 1 month before the 04/25/2023 incident "I complained a lot...[Caregiver C] called me names all the time...I had to stay in my room...[Assistant Administrator D] had us fill out papers on things [Caregiver C] said...write down things [s/he] did wrong...Eventually [Assistant Administrator D] got [Caregiver C] fired from here."
Neither Administrator A nor other management staff spoke to him/her about any of his/her concerns until after the 04/25/2023 incident.
"I don't want to be here. I want to find somewhere else to go."

Administrator A - on 08/03/2023 at 2:09 PM, Surveyor interviewed Administrator A who stated:
Prior to 04/25/2023 s/he was aware "[Caregiver C] was a bully...a lot of staff didn't want to work with him/her."
S/he received Resident 1's 04/23/2023 statement on 04/24/2023 and "most likely talked to [Caregiver C] about [his/her] behavior." Surveyor asked if s/he conducted an investigation or documented the talk with Caregiver C. S/he replied, "I don't have stuff to be writing on when

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getting phone calls left and right."
On 04/25/2023 s/he received a report from Assistant Administrator D that Caregiver C yelled at Resident 2, withheld food and confined him/her to his/her room. In response, s/he did not suspend Caregiver C or start an investigation until the following day.
S/he did not investigate Resident 1's 04/26/2023 allegations about Caregiver E. S/he did not interview Caregiver E as part of the investigation into Caregiver C to determine if [Caregiver E] had participated in and/or failed to report abuse or neglect on or before 04/25/2023. S/he did not interview other staff or residents to determine if they had concerns about Caregiver E. Caregiver E quit on 05/08/2023, was rehired on 06/12/2023, and s/he continues to work at the facility.
There was no additional documentation of investigations or steps to protect residents other than what was submitted in the self-report.
Administrator A stated s/he is responsible for conducting misconduct investigations along with assistance from the corporate office. S/he provided Surveyor a copy of the current Abuse and Misconduct policy.

RECORD REVIEW - On 08/07/2023 Surveyor reviewed the current "ABUSE/MISCONDUCT POLICY" which read in part:

"...All employees...are required to immediately report any known or suspected resident abuse to the Director (Administrator)...When allegations involve the possible commission of a crime, reporters should also separately notify law enforcement...In the event of physical abuse, the resident shall be examined by the attending physician to determine the extent and nature of any injuries...Upon learning of an incident of

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N 158	Continued From page 8 alleged misconduct, the Director shall take whatever steps are necessary to ensure that resident(s) are protected from subsequent episodes of misconduct while a determination on the matter is pending...'Abuse' means any of the following, if done intentionally: A. An act, omission or course of conduct by another that is not part of a treatment plan...and does any of the following: 1. Results in physical pain or injury, illness...2. Intimidates, humiliates, threatens, frightens, or otherwise harasses a resident. 3. Substantially disregards a resident's rights...or a caregiver's duties and obligations to the resident..." On 08/07/2023 Surveyor reviewed Resident 1 and Resident 2's complete facility records. Both residents' current individual service plans described them as being able to communicate effectively and make their needs known. Cross Reference: N0348 DHS 83.32(3)(d) Rights of Residents: Free from Mistreatment	N 158		

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N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 2 was free from abuse. On 04/25/2023, Caregiver C denied Resident 2 food and drink, yelled and him/her and confined Resident 2 to [his/her] room. DHS 83.02(1)(1) "Abuse" has the meaning given in s. 46.90 (1), Stats.(a):...Physical abuse...Emotional abuse (language or behavior that serves no legitimate purpose and is intended to be intimidating, humiliating, threatening,	N 348		

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frightening, or otherwise harassing, and that does or reasonably could intimidate, humiliate, threaten, frighten, or otherwise harass the individual...)... Unreasonable confinement or restraint."

This is a repeat deficiency being cited for the 2nd time. See Statement of Deficiency YU9Z11, dated 02/25/2021.

Findings include:

The Department received a complaint alleging residents were verbally abused by caregivers and residents were scared.

The Department also received a self-report from the provider on 04/26/2023 reporting an incident of abuse against Resident 2 by Caregiver C. The self-report included the following reports/statements:

An investigation summary dated 04/27/2023 authored by Administrator A. Administrator A wrote Caregiver C was suspended and ultimately terminated due to incidents that occurred on 04/25/2023 to include: "1. Yelling loudly at resident (Resident 2) and made that resident go to [his/her] room till [s/he] can behave. That is against resident rights. 2. Resident asked for milk and [Caregiver C] told [him/her] that [s/he] couldn't have any milk. Resident wanting to enjoy [his/her] supper but staff told [him/her] that [s/he] had to wait till [his/her] behavior was calmed down. Holding food from resident. Against resident rights. 3. Residents are scared of [Caregiver C], they stated that [s/he] is demanding and rude, rough with them..." [sic- all]

A written statement from Resident 2, signed and

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dated 04/26/2023. Resident 2 stated s/he requested milk at dinner and Caregiver C yelled at him/her and said s/he could not have it. Resident 2 said s/he yelled back and Caregiver C "told me to go to my room. I said no and [s/he] physically pushed me into room in my wheelchair [s/he] closed my door, and made me wait to be able to eat, [Caregiver C] has told me I'm incompetent to take care of myself, I do not feel safe @ Care Partners when [Caregiver C] is on shift." [sic-all]

A statement from Assistant Administrator D. S/he described a call s/he received on 04/25/2023 at 4:51 PM from Caregiver C reporting Resident 2's blood sugar was low at 96 mg/dl. Caregiver C said s/he had removed Resident 2 from the dining room and placed him/her in his/her room before Resident 2 had finished eating. Assistant Administrator D could Caregiver C "yelling over food and calming down", [Resident 2] was yelling back that [s/he] wanted to finish eating and Caregiver C told Resident 2 "not until [s/he] calmed down."

INTERVIEWS

On 08/03/2023 at 11:04 AM, Surveyor interviewed Assistant Administrator D. S/he recalled during the 04/25/2023 call s/he heard, "[Caregiver C] screaming at [Resident 2]. I could hear [Resident 2] saying something about [s/he] wanted to finish eating, [s/he] was still hungry [Caregiver C] was hollering at [him/her], 'No! You stay in your room until you calm down and grow up!'"

On 08/03/2023 at 2:09 PM, Surveyor interviewed Administrator A. S/he confirmed on 04/25/2023 Caregiver C yelled at Resident 2, denied him/her food and confined Resident 2 to his/her room. As

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a result of the incident Caregiver C was suspended on 04/26/2023 and fired on 04/27/2023. Administrator A said staff had reported concerns about Caregiver C prior to this incident and s/he was known to be a "bully."

On 08/07/2023 at 4:55 PM, Surveyor interviewed Caregiver E. S/he recalled the 04/25/2023 incident and said, "It was during dinner. I was outside, through the back window I could see down the hall...I could hear commotion in the building. I remember seeing [Caregiver C] pull [Resident 2]'s wheelchair backwards into [his/her] room. That's when I came in...they were yelling back and forth...then, [Resident 2] was yelling in [his/her] room with the door shut (that) [s/he] was gonna come out. I'm pretty sure [Caregiver C] was on the phone with [Assistant Administrator D]." Caregiver E said no management staff reported to the facility and s/he and Caregiver C provided care to Resident 2 for the remainder of 2nd shift. Caregiver E said Caregiver C and Resident 2 never got along well and they would yell back and forth. Caregiver E said preceding this incident s/he often worked 2nd shift with Caregiver C and s/he did not treat Resident 2 or other residents with respect. Caregiver C would yell, deny snacks, deny phone access and once Resident 2 reported Caregiver C left him/her on the toilet for more than an hour. Caregiver E said descriptions of Caregiver C as a bully were accurate. Caregiver E said s/he didn't report the concerns to management because "I don't know, I guess I kind of feel like other people had known too and they would say something."

On 08/07/2023 at 4:24 PM, Surveyor interviewed Resident 2 and asked about Caregiver C. Resident 2 replied, "Oh [s/he] was bad. [S/he] would purposely try to get the wrong nerves out of

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	0011954	A. BUILDING: _____ B. WING _____	R-C 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS STEVENS POINT 2	3349 BUILDING B WHITING AVENUE STEVENS POINT, WI 54481

(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 348	Continued From page 13 you. I wanted to be [his/her] friend. [S/he] didn't want to hear about it...[Caregiver C] was a bully... [Caregiver E] would see it and went along with it. Everyone went along with [Caregiver C]...(The bad things)...did go on for a while." RECORD REVIEW On 08/03/2023 Surveyor reviewed the provider's current Abuse and Misconduct Policy, provided by Administrator A. The policy read in part, "Care Partners...believes that all people deserve dignified, loving care...Our plan shall assure protection of each resident from possible abuse...'Abuse' means any of the following, if done intentionally....An act, omission or course of conduct by another that is not part of a treatment plan...and does any of the following: 1. Results in physical pain or injury, illness...2. Intimidates, humiliates, threatens, frightens, or otherwise harasses a resident. 3. Substantially disregards a resident's rights...or a caregiver's duties and obligations to the resident..." Surveyor reviewed Resident 2's facility record on 08/07/2023. Resident 2 was elderly with diagnoses to include anemia, edema, vascular disease, major depressive disorder-single episode, schizoaffective disorder, urinary incontinence and type 2 diabetes. Resident 2's current individual service plan dated 03/01/2023, identified his/her need for staff assistance with ambulation in either a wheelchair or walker and the need for staff assistance with transfers during times of weakness. Resident 2 was described as "very friendly likes to be involved with others...not aggressive or combative...can make needs known...Is diabetic...Provide three meals and snacks daily..."	N 348		

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N 348	Continued From page 14 Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect	N 348		
N 427	83.38(1)(c) Leisure time activities. 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: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation and interview, the provider did not provide daily activity programming to meet the needs, interests and capabilities of the residents. Findings include: On 08/03/2023 beginning at 10:25 AM, Surveyor conducted a tour of the facility accompanied by Administrator A. Surveyor observed a posted activity calendar for August 2023. The first four days of the month were blank. Beginning Saturday 08/05/2023, activities were listed but times were not included. For example on Monday 08/07/2023 the listed activities were:	N 427		

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N 427	Continued From page 15 Exercise Soft Music Price is Right Bingo in Afternoon I Love Lucy Show Evening Social Administrator A acknowledged the first 4 days on the calendar were blank. S/he explained they had an activity person but s/he didn't work out and s/he was hoping to shift one of his/her current caregivers to the activity coordinator position in the next two weeks. During a follow up interview on 08/07/2023 at 3:06 PM, Administrator A said caregivers are supposed to be doing activities but s/he knows that is not always happening. Surveyor was on site for 2 hours on 08/03/2023 and periodically during the day on 08/07/2023. Surveyor did not observe any activities occurring. Surveyor interviewed Resident 1 on 08/03/2023 at 12:27 PM and asked how s/he liked living at the facility. S/he replied, "I don't like it at all. All I can do is sit here." Resident 1 said there are no activities and there have not been any for a "long time." Surveyor interviewed Resident 2 on 08/07/2023 at 4:24 PM . Surveyor asked if the provider offers activities. S/he replied, "Not anymore, there are not any activities. They used to have balloon volleyball, but not anymore." Resident 2 said it had been "a couple of months at least" since they had an activity person but commented they have a nice activity room for when they do hire someone. Surveyor asked about the activities listed on the posted calendar. Resident 2 replied, "That calendar is false. They are not happening."	N 427		

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N 427	Continued From page 16 On 08/07/2023 Surveyor reviewed Resident 2's current individual service plan dated 03/01/2023 which read in part, "Leisure Time Activities...loves to visit with others ...Reading, soft music, games and activities." On 08/09/2023 Ombudsman B sent Surveyor an email and wrote about a recent visit, "My visit on 7/19 (2023), no activities going on. Activities listed on a handwritten calendar, no times. [Administrator A] shared [s/he] had a plan to get an activity person started 'in two weeks' one of [his/her] caregivers was going to take that position." [sic - all] According to the National Library of Medicine, "...A critical aspect of supporting people with dementia is facilitating their participation in meaningful activities...activity provision for people with dementia goes beyond mere pleasure to meeting fundamental psychological needs...spiritual/religious activities address the need for death preparation; intergenerational activities address the need for intergenerational relationships; re-acquaintance with previously conducted leisure activities addresses the need for a sense of control and to achieve life goals; and pursuit of new leisure activities addresses the need to be creative...Conclusion: We argue for the importance of activity provision for people with dementia to help promote wellbeing among an increasing proportion of older people." Source: https://pubmed.ncbi.nlm.nih.gov/26933079/, retrieval date 08/16/2023 The provider is licensed to serve up to 16 non-ambulatory residents from the following client groups; irreversible dementia/Alzheimer's, terminally ill, physically disabled or advanced age.	N 427		

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{N 491}	Continued From page 17	{N 491}		
{N 491}	83.44(2)(c) Interior floors, walls and ceilings. Every interior floor, wall and ceiling shall be clean and in good repair. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all interior floors were clean and in good repair. Carpeting in the common areas of the facility was badly worn, stained and had areas of seam separation. This is an uncorrected, repeat deficiency being cited for the 4th time. See Statements of Deficiency: QZ1512, dated 07/12/2018 YU9Z12, dated 06/29/2021 YU9Z13, dated 09/01/2022 Findings include The provider is licensed to serve up to 16 non-ambulatory residents from the following client groups; irreversible dementia/Alzheimer's, terminally ill, physically disabled or advanced age. Surveyor entered the facility on 08/03/2023 at 10:25 AM accompanied by Administrator A. Surveyor observed the carpeting in the front common area/sitting room was worn and badly stained. There were up to 6 areas of large, dark stains. At least 1 of the stained areas was approximately 3' long by 1' wide. In front of the love seat there an area of seam separation that was approximately 4" long by 1" wide and exposed white threads were visible under the brown carpet.	{N 491}		

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{N 491}	Continued From page 18 Surveyor toured the rest of the facility with Administrator A. Surveyor observed the carpet was very worn with stains similar in size and color throughout. In one hallway there was seam separation 3' long by 1" wide and exposed white threads under the brown carpet. Administrator A acknowledged Surveyors observations of the poor condition of the carpeting throughout the building and said s/he has been requesting that it be replaced by the corporate office. Administrator A stated maintenance has told him/her the carpeting so so thin and worn, it is difficult to shampoo anymore. On 08/03/2023 at 12:50 PM, Surveyor interviewed Caregiver F. S/he acknowledged Surveyors observations about the worn and stained carpet. S/he said, "We could use improvements on the building" and added it was "definitely" time to replace the carpet. On 08/08/2023 at 8:45 AM, Surveyor interviewed Ombudsman B. S/he stated the issue with carpet maintenance has been ongoing at the facility for years. During his/her most recent visit on 07/19/2023, s/he observed the carpet was in very poor condition and s/he believed the areas of seam separation were a tripping hazard as the facility serves memory care residents that have impaired ambulation abilities.	{N 491}		