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 04/30/2024

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 000}	Initial Comments On 02/27/2024 and 02/28/2024 Surveyor conducted facility visits to investigate 2 complaints and verify correction of 4 previous deficiencies. Two self-reports were received and reviewed during the survey. Information was collected through 03/14/2024. A 3rd complaint was received on 04/24/2024, Surveyor returned for an onsite visit on 04/25/2024 and information was collected through 04/30/2024. Three (3) of 3 complaints were substantiated. Two (2) of 4 previous citations were repeat violations. Eleven (11) new deficiencies were identified. Census: 10 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	{N 158}		

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

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{N 158}	Continued From page 1 report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on observation and interview the provider did not take immediate steps to protect residents and did not conduct investigations into allegations of abuse/neglect to determine if the incident needed to be reported to the Department within 7 calendar days. -Administrator A did not thoroughly investigate allegations of abuse, received on 01/03/2024. -Administrator A did not investigate an allegation of verbal abuse against Caregiver H, received on 01/10/2024. -Administrator A did not take immediate steps to protect residents or investigate allegations of neglect impacting multiple residents, received on 01/15/2024. This is a repeat deficiency being cited for the third time. See SOD YU9Z11, dated 09/01/2022 and SOD YU9Z14, dated 08/16/2023. 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 alleging concerns with the provider's response to a report of potential abuse.	{N 158}		

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{N 158}	Continued From page 2 Surveyor reviewed Stevens Point Police report C24-00256 on 02/27/2024. "On 01/04/2024, I [Detective R], was contacted by Adult Protective Services [APS - Case Worker S]...requested law enforcement's assistance in regards to an abuse to an elder investigation at Care Partners..." The allegations received by APS included, "[Caregiver H] has slapped [Resident 1] in the face and is constantly yelling and screaming at [him/her] and verbally abusing [him/her]..." APS Worker S had been onsite on 01/03/2024 and "[Resident 1] is terrified to be at Care Partners and mentioned staff hurting [him/her] and the specific staff [Caregiver H] grabbing [his/her] wrist....[Resident 1] expressed that [s/he] does not feel safe being at Care Partners and wants to be somewhere else." On 01/10/2024 and 01/15/2024, Detective R and APS Worker S returned to the facility to continue the investigation. During an interview with Caregiver H, s/he disclosed an unrelated incident of potential neglect. Caregiver H reported 1 month ago, s/he left at the end of 1st shift and returned the next day to find the residents were still wearing their same clothes and "everyone was soaked" with incontinence briefs "about to burst." Detective R wrote, "We advised [Caregiver H] that we would address that issue with [Administrator A]. [Caregiver H] stated that [s/he] had already reported it to [Administrator A]." Detective R wrote on 01/10/2024, they informed Administrator A about the allegations made against Caregiver H and the allegations made by Caregiver H. Administrator A said s/he knew Caregiver H was lazy, s/he was aware of a prior incident of Caregiver H yelling and Resident 2	{N 158}		

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{N 158}	Continued From page 3	{N 158}		

and "it was [his/her] intention to let [Caregiver H] go..." Detective R wrote, "I explained to [Administrator A] that, due to [Resident 1]'s dementia, lack of injury and witness statements ...I would not be requesting charges. On 02/01/2024, Detective R made a follow up call to Administrator A who stated Caregiver H was not terminated but reassigned to building 1 (sister facility across the parking lot) where Administrator A's office is.

Surveyor reviewed portions of Resident 1's facility record on 03/06/2024. Resident 1 was admitted on 01/09/2023. S/he was elderly with an activated power of attorney for health care. Diagnoses included bipolar disorder, schizophrenia and dementia.

Upon request on 02/28/2024, Administrator A provided Surveyor a binder and said it contained documentation of all investigations s/he had completed since 01/01/2024. Surveyor reviewed the binder and noted the following two documents authored by Administrator A dated 01/03/2024 and 01/10/2024:

01/03/2024
" Administrator A was informed by APS they were investigating allegations of caregiver abuse against Resident 1. Administrator A wrote s/he was not informed of the name of the caregiver but was instructed by the corporate office to conduct an investigation.
" Administrator A interviewed Resident 1 who gave conflicting information. S/he said s/he did not feel safe at the facility, but then said staff were nice. S/he said twice s/he had been hurt, but that it was long ago. Administrator A did not describe an assessment to determine if Resident 1 had bruises or other signs of abuse.

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{N 158}	Continued From page 4 " Administrator A did not interview any other residents. (During onsite visits 02/27 and 02/28, Surveyor observed at least 2 residents were interviewable, Residents 2 and 5.) " The documented listed the 10 current caregivers including Caregiver H. Administrator A documented brief interviews with 4 of 10 caregivers. The interviews consisted of asking if they were aware of abuse; all said no. Only 1 interview note mentioned Resident 1 specifically. " Administrator A did not document an interview with Caregiver H and the investigation was concluded at 11:00 AM on 01/04/2024. 01/10/20241 " "[APS S] and [Detective R]...came to investigate allegations of resident abuse against [Resident 1]...They then told me they are investigating [Caregiver H] for verbal abuse...I stated that I have not seen that, but I was told [s/he] can be lazy and that [s/he] needs more training and that I will take [him/her] off the schedule but they told me not to do that yet...they are coming back Friday morning to talk to [him/her]." " The document did not include information about APS S and Detective R's return visit on 01/15/2024. It did document the allegations of neglect made by Caregiver H or identify any steps taken by Administrator A to protect residents or conduct further investigation. It did not include any additional investigative steps take by Administrator A after learning the abuse allegations specific to Caregiver H. " On 02/28/2024 at 4:41 PM, Surveyor interviewed Administrator A and asked if s/he investigated allegations of misconduct made against Caregiver H and if s/he investigated Caregiver H's allegations that residents were neglected by not receiving incontinence care.	{N 158}		

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{N 158}	Continued From page 5 Administrator A stated: " S/he interviewed some people on or after 01/03/2024 when APS was first at the facility and s/he had knowledge of an abuse investigation. This did not include an interview with Caregiver H. " On 01/10/2024, Detective R informed him/her the abuse allegations were against Caregiver H. " In response, Administrator A reassigned Caregiver H to building so Administrator A could "see [him/her] during the day." Administrator A did not take any investigative steps or complete documentation after receiving the new information about Caregiver H on 01/10. S/he explained since law enforcement did not have criminal charges, s/he did not think s/he had any further responsibility to conduct an investigation. " S/he did not investigate allegations about incontinence care not being provided and explained his/her impression that the 1st caregivers reporting the allegations were often as much to blame as the 3rd shift because 1st shift does not do their checks right away. Administrator A said s/he did not increase supervision of caregivers or otherwise monitor to ensure resident needs were being met. Cross Reference: N0161 DHS 83.12(3) Investigate Injuries of Unknown Source N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations Y3244 CH 50.09(1)(L) Care	{N 158}		
N 161	83.12(3)(a) Investigate injuries of unknown source.	N 161		

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N 161	Continued From page 6 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 observation and interview, the provider did not ensure an investigation was completed in an effort to determine the source of an injury sustained by Resident 3. 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. Upon request on 02/28/2024, Administrator A provided Surveyor a binder and said it contained documentation of all investigations s/he has completed since 01/01/2024. Surveyor noted incident reports which documented injuries of unknown origin but did not include evidence of investigations to determine the causes of the injuries. For example, there was an incident report dated 12/26/2023 for Resident 3 that read, "Writer noticed a mark on head resident said it's from the other day but writer stated mark looked fresh primary contact confirmed it was there yesterday when [s/he] came to visit... Action take: notified director, incident report, head assessment." The report documented an attempted call to the physician, but the number was disconnected.	N 161		

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N 161	Continued From page 7 Surveyor reviewed portions of Resident 3's record on 03/06/2024. Resident was admitted 02/26/2023, was elderly with diagnoses to include "moderate to Severe Dementia," Parkinson's disease and "mixed receptive language disorder." Surveyor reviewed caregiver notes in the weeks preceding the injury and no incident or potential cause was documented. On 02/28/2024 at 4:41 PM, Surveyor interviewed Administrator A and asked if there was an investigation into Resident 3's head injury on 12/26/2023. Administrator A replied, "We sent [him/her] out to have head evaluation." Surveyor asked again if there was an investigation into the cause. S/he replied, "I probably just asked and nobody knew and they found it that way. We called his POA (power of attorney - legal representative)." Administrator A said Resident 3 would not have the ability to accurately report the cause of the injury. Administrator A confirmed there was no additional documentation of an investigation for the incident report and his/her process in circumstances like this is to document the injury and make notifications. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations	N 161		
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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N 196	Continued From page 8 operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, interview and record review Licensee B did not ensure the CBRF and its operation comply with all laws governing the CBRF. The is a repeat deficiency being cited for the second time. See Statement of Deficiency 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. During the past 6 years and over the course of 5 previous surveys, the provider displayed a pattern of ongoing noncompliance with regulations. The current survey YU9Z15, ending on 04/30/2024 identified 11 new deficiencies resulting from 3 of 3 substantiated complaints and 2 of 4 uncorrected deficiencies. The 11 new deficiencies included the following recites: " Caregiver: Investigating Abuse & Neglect - 3rd recite and uncorrected from YU9Z14 " Licensee Ensures Facility Complies with Laws - 2nd recite " Rights of Residents: Receive Medications - 2nd recite " Service Plans Updated Annually Or On Changes - 2nd recite " Leisure Time Activities - 2nd recite and	N 196		

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N 196	Continued From page 9 uncorrected from YU9Z14 On 02/27/2024, Surveyor interviewed Administrator A and Regional Registered Nurse (RN) C. Administrator A said Licensee B had not been onsite at the facility since the last survey ending 08/16/2023. RN C said regional staff share information with Licensee B as needed. On 03/11/2024, Surveyor sent an email to Licensee B which read, "I am hopeful your administrator and/or regional staff have informed you of the Department's survey work at both Stevens Point locations. I just sent an email to [Administrator A] asking to schedule the exit conference Weds 3/13 at 8:30 or 9:00am. I will need about an hour to ask some follow up questions and then will review the preliminary findings, which are significant. I will be sending a Microsoft Teams invite for this meeting...I would like to include you...Does this date/time work for you? Thank you" Licensee B responded, "Yes this will work with my schedule please send me an invite also." Surveyor scheduled the exit conference via Microsoft Teams on 03/13/2024 at 8:30 AM and sent Licensee B a meeting invite. On 03/13/2024 at 8:30 AM, only Administrator A and Regional RN H joined the meeting. Surveyor asked if Licensee B would be joining and RN H replied, "No, it would be unprecedented," and stated s/he was surprised Surveyor thought otherwise. RN H asked if Licensee B had ever joined an exit conference with Surveyor in the past. Surveyor explained Licensee B had not attended past exit conferences but Licensee B was informed the findings of the current survey were significant and agreed to attend. Licensee B did not join the meeting any time prior to the conclusion at 11:37 AM and did not subsequently	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 196	Continued From page 10	N 196		

contact the Department to review the findings or provide additional information.

The current survey is the 5th consecutive survey with substantiated complaints, uncorrected deficiencies and/or repeat deficiencies. This survey event history is as follows:

SOD YZYN12, dated 07/12/2018 - 1 deficiency
" Interior Floors, Walls and Ceilings

SOD YU9Z11, dated 02/25/2021 - 1 of 1 complaint substantiated, 8 deficiencies
" Caregiver: Investigating Abuse & Neglect
" Orientation
" Advanced Directives
" Resident Rights: Free From Mistreatment
" Resident Rights: Self-Determination
" Pre-Admission and Ongoing Assessments
" Service Plans Updated Annually Or On Changes
" Infection Control Program
" Special order: "the Department of Health Services HEREBY ORDERS that Care Partners Stevens Point 2 NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations in Statement of Deficiency (SOD) #YU9Z11 are corrected..."
" Special order: " Pursuant to Wis. Stat. §§ 50.03(5g)(b)3. and (b)6., EFFECTIVE IMMEDIATELY, the licensee shall comply with requirements specified by Wis. Admin. Code § DHS 83.32(3)(d). That is, the licensee shall ... ensure the provision of all services to meet residents' physical ...health needs. At a minimum, the licensee's corrective measures will include the development (or revision) of written procedures and staff training to address: Health Monitoring, including how the licensee will: - monitor and document changes in the resident's

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N 196	Continued From page 11 health ... obtain timely medical care (clinical assessments, prompt medical treatment), and - review and revise individualized service plans annually or when there is a change in a resident's needs, abilities or physical or mental condition." SOD YU9Z12, dated 06/29/2021 - 1 of 8 deficiencies uncorrected and 3 new deficiencies " Advanced Directives " Infection Control Program " Interior Floors, Walls and Ceilings SOD YU9Z13, dated 09/01/2022 - 2 of 2 complaints substantiated, 2 of 3 deficiencies uncorrected and 7 new deficiencies " Licensee Ensures Facility Complies with Laws " Rights of Residents: Receive Medication " Pre-Admission and Ongoing Assessments " Medication Error or Adverse Reaction " Infection Control Program " Resident Records Safeguarded " Interior Floors, Walls and Ceilings SODYU9Z14, dated 08/16/2023 - 1 of 1 complaint substantiated, 6 of 7 deficiencies uncorrected and 4 new deficiencies " Caregiver: Investigating Abuse & Neglect " Resident Rights: Free From Mistreatment " Leisure Time Activities " Interior Floors, Walls and Ceilings " Special Order: Pursuant to Wis. Stat. § 50.03(5g)(b)6., the licensee shall develop and implement corrective measures to ensure the provision of 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.	N 196		

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N 196	Continued From page 12 During the surveys conducted between 2018-2023; Accurate documentation of advanced directives was not in the resident records and paramedics performed CPR on a resident against his/her wishes. Infection control programs were not implemented consistent with current standards of practice. Training was not provided, investigations into allegations of abuse were not conducted and resident records were not safeguarded. The facility was not well maintained to provide a homelike environment and leisure time activities were not provided. Medications were not administered as ordered and assessments were not completed. Two residents were subjected to neglect and 1 of the residents died as a result. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0161 DHS 83.12(3) Investigate Injuries of Unknown Source N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medications N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0400 DHS 83.37(1)(a) Written Orders for Medications, Supplements. N0415 DHS 83.37(2)(d) Documentation of Medication Administration N0416 DHS 83.37(2)(e) Other Administration Given or Delegated by RN N0427 DHS 83.38(1)(c) Leisure Time Activities Y3244 CH 50.09(1)(L) Care	N 196		

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 04/30/2024

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 214	Continued From page 13	N 214		
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, interview and record review, Administrator A did not supervise the daily operations of the CBRF to ensure residents received necessary care and services and their rights were protected. Administrator A did not ensure 2 of 4 previous citations were corrected and 11 new deficiencies were identified during the current survey. In addition, Administrator A quit abruptly on Saturday, 04/20/2024 and prior to his/her departure, s/he did not ensure systems were in place to ensure continuity of care and treatment for residents. Findings include: The provider is licensed to serve up to 16 non-ambulatory residents from the following client groups; irreversible dementia/Alzheimer's,	N 214		

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 04/30/2024

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

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N 214	Continued From page 14 terminally ill, physically disabled or advanced age. As a result of the current survey, four of 4 complaints were substantiated, two of 4 citations from the previous survey were uncorrected and 11 new deficiencies were identified. Administrator A was in his/her role during both the previous and current survey. Administrator A did not ensure Resident 1 received adequate care or health monitoring and did not revise individual service plans (ISPs) to ensure Resident 1 and 6 were served meals that were safe and met their dietary needs. S/he did not ensure medication orders were maintained at the facility, documentation of medication administration was accurate, delegation by a registered nurse was current or that all residents received medications as prescribed. Administrator A did not ensure investigations into alleged caregiver misconduct or injuries of unknown origin were conducted. In addition, the following concerns were identified: On 04/25/2024 Surveyor arrived onsite at 11:33 AM and was informed by caregivers that Administrator A quit abruptly over the weekend on 04/20/2024. At 11:35 AM, Surveyor interviewed Administrator T who said s/he was onsite to provide a management presence, however s/he was unfamiliar with the facility systems, residents or the caregivers. Administrator T said s/he was unsure how many residents lived in the facility and would need to contact the corporate office to provide Surveyor with accurate resident and staff rosters. On 04/25/2024, Surveyor's observations and interviews revealed preliminary concerns that caregivers placed Residents 1 and 6 at risk for choking by serving whole foods contrary to their	N 214		

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	0011954	A. BUILDING: _____ B. WING _____	R-C 04/30/2024

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

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N 214	Continued From page 15 needs and physician orders for texture modified diets. Administrator T said s/he was unaware of the residents' needs, if the orders in the file for textured modified diets were accurate or current and said some of the documentation was conflicting. Surveyor also identified health monitoring concerns for Resident 1 who complained of blood in his/her urine, burning during urination and frequent urination. Resident 1 said the provider was not helping him/her see a doctor. Surveyor requested records about Resident 1's needs in this area. Administrator T said Administrator A left the office and records in disarray and Administrator T was unable to locate relevant records. For example, on 04/25/2024 Administrator T was unable to locate orders for 2 of 2 medications administered to Resident 1 since 04/02/2024 or show satisfaction of a physician's order on 03/14/2024 for a urinalysis. On 04/30/2024 at 4:33 PM, Surveyor conducted a follow up interview with Administrator T. S/he said the process to obtain the records from Resident 1's physicians had been very challenging and s/he still had not been able to get one of the requested medication orders. Administrator T said a recently obtained after visit summary from the prescribing physician indicated the medication was potentially discontinued on 04/26/2024, but the medication was still being administered as of 04/29/2024. Administrator T said s/he would continue to try to get clarification. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0161 DHS 83.12(3) Investigate Injuries of Unknown Source	N 214		

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 04/30/2024

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

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N 214	Continued From page 16 N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medications N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0400 DHS 83.37(1)a) Written Orders for Medications, Supplements. N0415 DHS 83.37(2)(d) Documentation of Medication Administration N0416 DHS 83.37(2)(e) Other Administration Given or Delegated by RN N0427 DHS 83.38(1)(c) Leisure Time Activities Y3244 CH 50.09(1)(L) Care	N 214		
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 observation and interview, the provider did not ensure Resident 4's right to receive all medications prescribed. On 02/26/2024, Resident 4 received 8 times the dose of insulin that was prescribed and was treated in the emergency department (ED) for 7 hours due to insulin overdose. Upon discharge the physician ordered a 10 day increase in Resident 4's prescribed magnesium. Resident 4 did not receive the additional daily dose of the magnesium between 02/27-03/08/2024.	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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

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N 352	Continued From page 17 On 04/02/2024, Resident 1 was prescribed estradiol cream to be applied daily for 14 days, then 2-3 times/week thereafter. After the initial 14 days, caregivers continued to administer the cream daily through 04/28/2024. This is a repeat deficiency being cited for the 2nd time. See Statement of Deficiency YU9Z12, 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. The Department received a complaint alleging concerns with medication errors. POLICY: Surveyor reviewed the provider's medication administration and medication error reporting policies (on 03/10/2024) which read in part: "It is the policy of Care Partners Assisted Living ...that all medications are...administered, and documented correctly per state regulations .... With the increased needs of individuals in assisted living facilities, facilities must have the ability to manage complex medication regimens ...Although medications can improve the functional status and quality of life for residents, improperly managed medications can also cause serious adverse consequences ... The following are guidelines for...specific administration procedures...Prior to administration, the medication and dosage schedule on the resident's MAR are compared with the medication label. This is done three (3) times. If the label and	N 352		

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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

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N 352	Continued From page 18 the MAR are different, the resident's chart is checked for the correct dosage and the Director is notified of the discrepancy. Six recognized rights: 1. Right drug 2. Right resident 3. Right time 4. Right dose 5. Right route 6. Right dosage form [sic]...A medication error is a preventable event resulting in the incorrect administration of a medications, or harm or potential harm of a resident...the practitioner's written order identifies the prescribed medication, dose, time and route of administration..." RESIDENT 4: The Department received a self-report from the provider describing a medication error on 02/26/2024. The report authored by Administrator A read, "Resident was given 100 units of Humalog, [s/he] was only to receive 12 units. [Caregiver O] noticed error immediately and called me and I stated to send [him/her] out to the hospital before [s/he] crashes...Resident did come back at 1:30 am from hospital with no new orders. [Caregiver O] was given re-education on following the 6 rights of medication administration. Written warning also." Surveyor requested and received the emergency department (ED) discharge summary from the hospital on 03/08/2024. It read in part, "Accidental insulin overdose" Resident 4's blood glucose was as low as 62 mg/dl and required oral food administration, an 25g ampule of 50% dextrose and a D5 infusion (both commonly used to treat hypoglycemia/very low blood sugar.) The treatments were administered in response to blood glucose levels with a "trend downward at 62 and slowly upwards to 88, 76 and 80. Overall patient intermittently agitated secondary to baseline dementia...in the ER for a total duration of 7 hours before showing a stable trend in	N 352		

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 04/30/2024

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

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N 352	Continued From page 19	N 352		

[his/her] glucose readings without the need for IV administration of dextrose." Discharge diagnoses were insulin overdose and hypomagnesemia (magnesium deficiency) and there were new orders to "Increase magnesium from twice daily to 3 times daily over the next 10 days and recheck magnesium levels."

*Magnesium is an essential nutrient for the brain and body. It helps regulate blood sugar, among its many benefits. Yet a magnesium deficiency is often seen in people with diabetes...more prevalent with type 2...Taking a magnesium supplement, however, can increase your magnesium blood level and improve diabetes control."
Source:
https://www.healthline.com/health/diabetes/magnesium-and-diabetes, retrieval date 04/24/2024

*Surveyor noted a conflict between Administrator A's report stating there were no new orders but the hospital records indicated orders for a temporary, increased dose of magnesium.

Surveyor sent Administrator A an email on 03/06/2024 at 6:21 AM, and requested the current individual service plan (ISP), signed prescriber orders for insulin 02/01 through present, February and March 2024 medication administration records (MARs) and the provider's copy of the emergency room discharge summary.

On 03/06/2024 and 03/11/2024, Administrator A emailed documentation from Resident 4's record. Surveyor noted inconsistencies between orders and the provider's documentation for the dosages of insulin and magnesium (underlined for emphasis).
Resident 4 was elderly and admitted on

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 04/30/2024

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

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N 352	Continued From page 20 08/28/2023 with diagnoses to include stage 3 kidney disease and type 2 diabetes. According to the ISP last updated 08/30/2023, Resident 4 relied on staff assistance for medication management. The ISP also read, "Humalog 10 units at each meal." A medication order signed by Advanced Practice Nurse Practitioner (APNP) E on 08/21/2023 for magnesium 400 MG, twice daily and insulin lispro (Humalog) "100 UNIT ML/Inject 10 units subcutaneously" MAR - "HUMALOG 100 UNITS/ML KWIK (order date) 08/28/2023...INJECT 12 UNITS SUBCUTANEOUSLY 3 TIMES DAILY WITH MEALS." MAR - "MAGNESIUM 400 MG TABLES (order date) 08/23/2023...TAKE 1 TABLET BY MOUTH TWICE DAILY" - 02/27-03/10/2024 the medication was administered twice daily. Emergency department discharge summary dated 02/27/2024 at 1:24 AM, "Increase magnesium from twice daily to 3 times daily over the next 10 days and recheck magnesium level. Surveyor noted summary was faxed to Administrator A from the ED on 03/06/2024 at 10:32 AM. On 03/11/2024, Surveyor emailed Administrator A and wrote, "Has [s/he] had any follow up appointments or lab work since the 2/26/24 ED visit? The orders you sent dated 8/21/23 do not align with the medications listed on the MAR. Can you please provide more information about the following...The orders are for 10 units of Humalog...but the MAR prompts for 12 units 3x/day with meals..." Administrator A replied, "if you look at each medication on the mars there is a date when order was given 8/28/2024 for example. [S/he]	N 352		

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 04/30/2024

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

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N 352	Continued From page 21	N 352		

was just seen on March 7th with [his/her] primary see new orders are the same..." Administrator A attached insulin orders dated 03/07/2024. Administrator A did not provide confirmation that Resident 4's magnesium levels were checked 10 days after 02/27/2024.

On 03/12/2024 Surveyor emailed Administrator A and wrote, "that makes sense if there were orders on 8/28/23 (after of the 8/21/23 orders you sent.)...Do you have the 8/28/23 orders in [his/her] record? If so please send...The insulin orders you sent are written 3/7/24 so they don't confirm what the orders were in February...Thank you."

Administrator A replied and attached orders dated 08/28/2023 for 12 units of Humalog 3 times daily. The order was a copy sent from the pharmacy and the fax date stamp was 03/12/2024.

On 03/13/2024 at 8:30 AM, Surveyor interviewed Administrator A and asked about the process for obtaining discharge and after visit summaries. S/he said, "All staff are supposed to review them and then we fax them to the Pharmacy." Surveyor asked what the process is if a resident does not return with a summary and s/he replied, "They should always have one, but some family members do not like to bring them back....I usually check them all out but I am not always here when they arrive, so staff are supposed to give me the orders when they receive them." Surveyor inquired about Resident 4's 02/27/2024 discharge summary, noting there was a medication change for magnesium. Administrator A replied, "[S/he] did not come back with paperwork and is not good at providing the documents so I was unaware of the magnesium." Administrator A verified s/he did not obtain a copy

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 04/30/2024

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 352	Continued From page 22	N 352		

of the summary until requested by Surveyor. Surveyor asked if Resident 4's practitioner was informed the ED orders were not satisfied and Administrator A said s/he talked to the funding source caseworker. S/he did not say s/he informed the practitioner.

In conclusion: On 02/26/2024, Resident 4 received 8 times the dose of insulin that was prescribed; s/he was administered 100 units of Humalog (insulin) when the order was for 12 units. Resident 4's blood sugar dropped as low as 62 mg/dl and s/he spent 7 hours in the emergency department to regulate his/her blood sugar. Upon discharge on 02/27/2024, Resident 4 was diagnosed with magnesium deficiency and the physician ordered a medication change for magnesium from 400 mg twice daily to 400 mg three times daily for 10 days. Resident 4 did not receive the additional daily dose of the magnesium between 02/27-03/08/2024 because the provider did not obtain a copy of the discharge summary and was unaware of the medication change. In addition, the provider did not maintain current and accurate documentation of medication orders for Humalog creating a risk for future medication errors.

RESIDENT 1:
On 04/25/2024 at 2:03 PM, Surveyor was reviewing Resident 1's medications with Caregiver O. Caregiver O showed Surveyor Resident 1's April 2024 MAR which listed estradiol cream "Pea Sized amount...nightly for 2 weeks. Then every M/W/F". The medication started on 04/02/2024 and the MAR documented nightly administration as instructed from 04/02 - 04/16/2024. However, on 04/17/2024 when administration should have changed to Monday, Wednesday and Friday, the MAR continued to

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 04/30/2024

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 352	Continued From page 23 document the medication was administered every night. Caregiver O confirmed Surveyor's review of the MAR. While reviewing the medications, Caregiver F arrived for 2nd shift. Caregiver F said s/he last worked on Sunday 02/21/2024. S/he recalled administering the medication during the 8:00 PM medication pass and confirmed it was his/her initials on the MAR for that date/time. Caregiver F agreed according to the MAR instructions, the medication should not have been administered daily after 04/17/2024 and should not have been administered on a Sunday. Caregiver F did not have an explanation for why s/he administered the medication contrary to the instructions. On 04/25/2024, Surveyor reviewed Resident 1's record. Resident 1 was elderly with diagnoses to include dementia and schizophrenia. A signed physician's plan of care dated 01/09/2023, and the most current individualized service plan (ISP) dated 02/15/2024, indicated Resident 1 relied on staff assistance for all medication management and administration needs. On 04/26/2024, Administrator T emailed Surveyor a copy of the order for the medication signed by Physician Assistant Y on 04/02/2024 at 10:31 AM. The order read, "Estradiol .1 MG/GM...use pea size amount nightly...for 2 weeks. Then use 2-3x weekly thereafter." Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0400 DHS 83.37(1)a) Written Orders for Medications, Supplements.	N 352		

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 04/30/2024

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 352	Continued From page 24 N0415 DHS 83.37(2)(d) Documentation of Medication Administration N0416 DHS 83.37(2)(e) Other Administration Given or Delegated by RN Y3244 CH 50.09(1)(L) Care	N 352		
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 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, interview and record review the provider did not ensure individual service plans (ISPs) were reviewed and revised when there was a change in residents' needs, abilities or physical condition. Resident 1 and Resident 6's ISPs were not revised to accurately reflect texture modified diets ordered by their physicians or to identify their diagnoses of diabetes and associated dietary needs. Caregivers routinely served foods that presented	N 389		

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 04/30/2024

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 389	Continued From page 25	N 389		

a choking risk and did not offer options for low carbohydrate or low sugar meal options.

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 the provider was not serving food consistent with physician ordered texture modified diets.

RESIDENT 1

DIETARY NEEDS

On 04/25/2024 at 11:45 AM, Surveyor observed the lunch meal. Caregiver G served Resident 1 a tuna fish sandwich on white bread cut in half, potato chips with ridges, green beans (approximately 2-3 inches long) and a cookie. Surveyor observed Resident 1 did not have any teeth. S/he ate the sandwich, chips, cookie and 2 green beans. Resident 1 requested another sandwich and ate half of it. S/he then pushed the plate away leaving the green beans.

At 12:21 PM, Surveyor joined Resident 1 at the table and asked about the meal. Resident 1 said s/he could not chew the green beans because s/he doesn't have teeth. S/he said, "I haven't had teeth in a long time."

On 04/25/2024 at 12:44 PM, Surveyor interviewed Caregiver O. S/he said caregivers are responsible for preparing and serving meals. S/he recalled receiving some dietary training but did not recall any training on texture modified diets. Caregiver O said there were currently no

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 04/30/2024

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 389	Continued From page 26	N 389		

residents who needed texture modified diets like mechanical soft or pureed. S/he said there were 3 diabetic residents [Residents 4, 6 and 7] and low sugar or low carbohydrate foods are only offered if their blood sugars are high.

At 1:49 PM, Surveyor interviewed Caregiver O and Caregiver G in the kitchen/dining area. They both acknowledged the green beans presented a choking hazard for Resident 1 (and Resident 6, see below) who does not have teeth. Caregiver O said in other facilities where s/he has worked, special diets are posted in the kitchen. S/he pointed out to Surveyor there were no signs in the kitchen to inform or remind caregivers of dietary needs.

Surveyor observed a dry erase board in the dining room with the aforementioned lunch meal and the anticipated dinner meal listed as chicken salad, dinner roll and carrot cake. Surveyor requested a copy of the printed weekly menu from the caregivers. Surveyor observed lunch meal on the printed menu for 04/25 did not align with the lunch served or the dinner meal on the board. Caregiver G agreed and said they often need to substitute when they don't have the food listed on the menu.

At 2:31 PM, Surveyor interviewed Administrator T. S/he explained s/he was not familiar with the residents because s/he was just providing coverage after former Administrator A separated employment abruptly on 04/20/2024. Administrator T looked in Resident 1's record for any documentation of dietary needs and located a physician plan of care (PPOC) signed and dated 01/09/2023. The PPOC read, "Diet...soft bite sized Dysphagia level 6"

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 04/30/2024

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 389	Continued From page 27 Surveyor noted according to the International Dysphagia Diet Standardization Initiative: "Level 6 Soft & Bite-Sized for Adults - What is this food texture level? Soft, tender and moist... Ability to ' bite off ' a piece of food is not required Ability to chew ' bite-sized ' pieces so that they are safe to swallow is required Bite-sized pieces no bigger than 1.5cm x 1.5cm in size Food can be mashed/broken down with pressure from fork... Why is this food texture level used for adults?...may be used if you are not able to bite off pieces of food safely but are able to chew bite-sized pieces down into little pieces that are safe to swallow. Soft & Bite-Sized foods need a moderate amount of chewing, for the tongue to ' collect ' the food into a ball and bring it to the back of the mouth for swallowing. The pieces are ' bite-sized ' to reduce choking risk... NO REGULAR DRY BREAD due to high choking risk! See https://www.youtube.com/channel/UC0I9FDjwJR0L5svIGCvIqHA/featured?reload=9 for instructions on how to make a Level 5 Minced & Moist sandwich, as this is also suitable for use on Soft & Bite-Sized diet... For safety, AVOID these food textures that pose a choking risk for adults who need Level 6 Soft & Bite-Sized Food - Sharp or spiky Corn chips and crisps...fruit, vegetable, meat, pasta or other food pieces larger than 1.5cmx1.5cm" source: https://iddsi.org/IDDSI/media/images/ConsumerHandoutsAdult/6_Soft_Bite_Sized_Adult_consume	N 389		

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 04/30/2024

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 389	Continued From page 28 r_handout_30Jan2019.pdf, retrieval date 05/01/2024. On 04/30/2024, Administrator T provided Surveyor with a recent medical visit summary for Resident 1. On 03/12/2024 Nurse Practitioner K wrote, "Elevated blood sugar...Assessment & Plan: Discussed the need for weight loss. Advised on reducing carb intake and avoiding white foods ..." Surveyor reviewed portions of Resident 1's facility record on 04/25/2024. Resident 1's face sheet documented s/he was elderly, admitted on 01/09/2023 and had diagnoses included bipolar disorder, schizophrenia and dementia. The face sheet indicated s/he was diabetic and the section titled "Diet order" read, "General, may need prompting to eat." The ISP dated 02/15/2024 read, "Eating...Needs meat cut into smaller pieces to avoid choking and due to no teeth..." "Special Diet...General diet, needs food cut up into smaller pieces due to choking and no teeth." The ISP: did not identify Resident 1's elevated blood sugar noted on 03/12/2024 or corresponding interventions to include reducing carb intake and avoiding white foods. did not identify Resident 1's physician ordered modified texture diet. instructed to cut food into smaller pieces, which did not accurately or completely describe dysphagia level 6 modifications. URINARY TRACT INFECTION RISK: "A urinary tract infection (UTI) is an infection of	N 389		

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 04/30/2024

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 389	Continued From page 29	N 389		

your urinary system....Symptoms...Frequent urination. Urge incontinence. Pain when you pee (dysuria). Blood in your pee (hematuria)...A UTI..most often happens when bacteria from your genital area enter your urethra. This can happen in a number of ways, like wiping yourself from back to front...You can also get a UTI when bacteria normally found in your urinary tract multiply to an unhealthy level. A healthcare provider treats UTIs with antibiotics...Left untreated, the infection continues to spread through your urethra, bladder and, ultimately, your kidneys. This can lead to sepsis. Sepsis is your body ' s dangerous reaction to an infection...It ' s important not to let infections go untreated. If you have symptoms of a UTI, get help from a healthcare provider."
source:
https://my.clevelandclinic.org/health/diseases/9135-urinary-tract-infections, retrieval date 05/01/2024
source:
https://my.clevelandclinic.org/health/diseases/25008-urosepsis, retrieval date 05/01/2024

On 04/25/2024 at 11:55 AM, Resident 1 was in the dining room and Caregiver G was present. Resident 1 announced s/he was going to the bathroom and walked to the bathroom located in his/her room. At 11:58 AM, Surveyor observed Caregiver G approach Resident 1's bedroom door. S/he did not enter to offer assistance or observe Resident 1 using the bathroom. Caregiver G closed the door and walked away. At 12:01 PM and at 12:26 PM, Resident 1 informed Surveyor s/he was suffering from frequent urination, blood in his/her urine and burning during urination. Resident 1 said the symptoms had been present for a while, s/he was distressed and asked for Surveyor's help getting a doctor's

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 04/30/2024

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 389	Continued From page 30 appointment. On 04/25/2024 at 1:49 PM, Surveyor interviewed Caregiver O. Caregiver O said Resident 1 is prone to UTIs and s/he had been having them "very often." Caregiver O said s/he was unaware of current symptoms and s/he just washed Resident 1's peri area "with soap" today. Surveyor interviewed Administrator T on 04/25/2024 at 2:31 PM, on 04/29/2024 at 10:58 AM and 04/30/2024 at 4:33 PM. On 04/25, Administrator T reviewed Resident 1's records and said the only documentation s/he could find regarding urinary concerns was a 1 page "Physician Visit From" from 03/12/2024 that noted a urinalysis was pending. S/he could not locate an after visit summary (AVS) for that appointment, the results of the UA or documentation of any other visits related to urinary concerns in 2024. On 04/29, Administrator T said s/he did obtain the AVS from the practitioner from the 03/12 visit, but s/he learned there was also a 04/02 visit with urology and s/he had yet not been able to locate or obtain documentation from that appointment. Administrator T said best practice is to always obtain AVSs and if a resident doesn't return with one to contact the practitioner to get it. Administrator T said they are "super important" because they include information about diagnoses, new care needs, medications, referrals and/or follow up visits. On 04/30, Administrator T said Resident 1's practitioner ordered a urinalysis with culture based on Resident 1's current symptoms. The sample was collected and tested today, results were suspicious for a UTI and antibiotics were prescribed pending the results of the culture.	N 389		

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 04/30/2024

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 389	Continued From page 31 On 04/30/2024, Administrator T emailed Surveyor visit summaries for medical appointments with Nurse Practitioner K on 03/12/2024 and Physician's Assistant N on 04/02/2024. Surveyor noted the summaries identified Resident 1's risk of UTIs, new diagnosis of urge incontinence and overactive bladder (OAB) and reviewed specific strategies for prevention and monitoring: 03/12: "Has bladder wall thickening. Continues to wipe incorrectly with urination but Care Partners staff are trying to help [him/her] with this per assistant with [him/her] today. States [s/he] has dysuria intermittently. Sees Urology in April." 04/02: Presents today for consultation regarding frequent UTI ...referred by Nurse Practitioner D ....has been treated for UTI 3 times in the last year ...When [s/he] gets UTI [s/he] describes symptoms of increased frequency, urgency, urge incontinence and occasional dysuria (burning during urination.) It does seem like symptoms improve/resolve after antibiotic treatment ...has not seen urology in the past ...Nonspecific mild diffuse urinary bladder wall thickening, which can be seen with urinary tract infection ...We had a lengthy discussion regarding recurrent UTIs and behavioral changes that [s/he] can make to help prevent them. We did discuss increasing fluid intake, urinating more frequently, avoiding irritating products in the [peri] area such as soaps ...We also discussed using cranberry products and probiotics ...We reviewed the signs or symptoms of UTI and my desire to limit testing to only when true signs or symptoms are present ...Reviewed true symptoms of UTI to include frequency, urgency, burning with urination ... (Regarding Urge incontinence and (OAB) discussed in detail as well as potential treatments	N 389		

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 04/30/2024

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 389	Continued From page 32 ...include bladder irritant avoidance, timed voiding, bladder training, pelvic floor exercises ...We will also do a trial of Myrbetriq, samples were provided today." During the aforementioned review of Resident 1's current ISP dated 02/15/2024, Surveyor noted it was silent to the history or risk of UTIs and: did not identify the new diagnoses of OAB and urge incontinence or interventions including bladder irritant avoidance, timed voiding, bladder training or pelvic floor exercises. did not identify the diagnoses of chronic UTIs or interventions including proper wiping, increased fluid intake, avoidance of irritating products like soap in the peri area, use of cranberry products or probiotics. did not identify signs/symptoms of UTIs including frequency, urgency or burning to allow for monitoring and early identification of possible infection. RESIDENT 6: On 04/25/2024, Surveyor observed the lunch meal. At 12:03 PM, Caregiver G served Resident 5 a tuna fish sandwich on white bread cut in half, potato chips with ridges, green beans (approximately 2-3 inches long) and a cookie. Surveyor observed Resident 6 did not have any teeth, took large bites of food and ate quickly. For example, s/he at the first half of the sandwich in 3 minutes and had most of the 2nd half of the sandwich in his/her mouth after another 2 minutes. While eating the sandwich and the potato chips, Resident was coughing in an apparent effort to clear food. After coughing, s/he would follow with a drink of juice and then immediately resume eating. Caregiver G did not	N 389		

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 04/30/2024

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 389	Continued From page 33	N 389		

check on Resident 6 or offer cues to slow down during the meal. Resident 6 coughed at least 9 times during the meal observation. At one point Resident 1 looked at Resident 6 while s/he was coughing and said, "Get that [man/woman] out of here!" Resident 6 at all of the meal except the green beans.

During the aforementioned interview with Caregiver O, s/he stated the following:
Resident 6 was not coughing due to illness and Resident 6 normally coughs during meals.
Resident 6 does not have teeth and s/he eats fast.
S/he was uncertain what the ISP said about a texture modified diet.
S/he agreed the green beans could be a choking hazard but commented, "I can't give an order for [his/her] food to be pureed."
S/he explained Resident 6's practitioner recently discontinued an order for a pureed diet, but even before it was discontinued, caregivers were not serving Resident 6's meals pureed.

On 04/25/2024 at 2:23 PM, Surveyor interviewed Registered Nurse (RN) L from Resident 6's funding source. S/he on 04/19/2024 at a care time meeting, a caregiver said they were cutting Resident 6's food instead of serving it pureed. RN E said his/her understanding was that Resident 6 needed food pureed and s/he told Administrator A it was important to clarify what the dietary needs were.

On 04/25/2024 at 2:31 PM Surveyor asked Administrator T about the situation. S/he located 2 PPOCs in Resident 6's record. One had an illegible signature and date. It documented a diagnoses of diabetes and dysphagia and ordered a mechanical soft diet. The second

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 04/30/2024

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 389	Continued From page 34	N 389		

PPOC was signed and dated 06/09/2023. It included the same diagnoses and ordered a pureed diet. Administrator T said s/he would continue to review the records and obtain more information.

Surveyor note: Dysphagia is a medical term for difficulty swallowing. Dysphagia can be a painful condition. In some cases, swallowing is impossible..Dysphagia can happen at any age, but it's more common in older adults. The causes of swallowing problems vary, and treatment depends on the cause...Symptoms associated with dysphagia can include: Pain while swallowing. Not being able to swallow. Feeling as if food is stuck in the throat or chest or behind the breastbone...Food coming back up, called regurgitation...Coughing or gagging when swallowing."
source:
https://www.mayoclinic.org/diseases-conditions/dysphagia/symptoms-causes/syc-20372028, retrieval date 05/01/2024

On 04/26/2024, Administrator T emailed Surveyor a "Physician Fax" dated 04/19/2024 sent from former Administrator A to Resident 6's physician and wrote, "Has a pureed diet, won't eat if pureed we have been cutting items in smaller pieces for [him/her] with no issues with choking. Please advise." The physician replied, "Please proceed as patient tolerates."

On 04/29/2024 at 10:58 AM, Surveyor interviewed Administrator T. Administrator T agreed the physician response to "proceed as patient tolerates" was not clear. S/he also agreed based on Surveyor's observations of Resident 6 coughing throughout the meal, the information Administrator A provided to the physician may not

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 04/30/2024

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 389	Continued From page 35	N 389		

have been accurate or complete. Administrator T said s/he would observe meals him/herself and follow up with the physician.

On 04/30/2024, Administrator T emailed Surveyor and wrote, "Today I observed breakfast & lunch for [Resident 6] and there were no concerns with the mechanical soft diet or coughing during meal times. I talked with [Caregiver O] and [s/he] stated that the mechanical soft diet is appropriate and there are no concerns. I did fax and update doctor." The email included a physician's order dated 04/30/2024 that read, "Patient to be on mechanical soft diet."

On 04/25/2024, Caregiver O provided Surveyor portions of Resident 6's record. Resident 1 was admitted on 06/12/2023. S/he was elderly with diagnoses to include Type 2 diabetes and dysphagia. Resident 6's ISP was only dated with the year "2024" and had signatures of caregivers acknowledging review of the plan between 01/08/2024 and 03/27/2024.

Resident 6's ISP read,

"Eating...Diabetes testing 3 times daily at meals."
"Special Diet - Pureed diet - general, can eat soft things but meats need to be cut up very small to avoid choking."
"Oral Care - [Resident 6] has no teeth..."

Surveyor noted a puree diet does not include cut up meats or soft things like bread. In addition, the ISP did not address dietary considerations given Resident 6's diagnosis of diabetes. While reviewing Resident 6's record, Surveyor noted at least one high blood sugar of 353 mg/dl prompting the paramedics to be called on 04/12/2024.

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 04/30/2024

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 389	Continued From page 36 "puree diet (IDDSI Level 4). You may have been recommended a puree diet if you are having trouble chewing or swallowing...A puree diet included foods that are smooth and lump free but may have a grainy quality. Foods should be moist and hold their shape on a spoon. These foods should not need chewing and should not be sticky. A blender, vitamiser or food processor will be required to produce foods of this texture...Foods to avoid - Whole or minced meats that have not been pureed in a blender...All breads...Cakes, pastry, pies...Vegetables that have not been pureed or well mashed..." source: https://www.health.qld.gov.au/__data/assets/pdf_file/0030/1065828/txt-mod-puree.pdf, retrieval date 05/01/2024. "When you eat or drink foods that have carbohydrates...your body breaks those carbs down into glucose (a type of sugar), which then raises the level of glucose in your blood....This is what you probably know of as your "blood glucose" or "blood sugar." When it comes to managing diabetes, the carbs you eat play an important role....Try to eat less of these: refined, highly processed carbohydrate foods and those with added sugar. These include sugary drinks like soda, sweet tea and juice, refined grains like white bread, white rice and sugary cereal, and sweets and snack foods like cake, cookies, candy and chips." https://diabetes.org/food-nutrition/understanding-carbs, retrieval date 05/02/2024. In conclusion: Resident 6 did not have any teeth and had a diagnosis of dysphagia. On 06/09/2023, Resident	N 389		

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 04/30/2024

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 389	Continued From page 37 6's physician ordered a pureed diet. On 04/19/2024 at a care team meeting, a caregiver said they had not been providing a pureed diet and only described a modification of cutting up meat. On 04/25/2024 Caregiver O told Surveyor they have not been offering Resident 6 a pureed diet and Resident 6 coughs when s/he eats. On 04/25/2024 Surveyor observed staff did not puree Resident 6's lunch meal. Resident 6 was served a sandwich on white bread, potato chips, green beans and a cookie. The entire lunch meal is on the list of foods to avoid on a pureed diet due to choking risk. Resident 6 ate quickly and coughed throughout the meal. Resident 6's ISP did not accurately or clearly reflect Resident 6's needs for a texture modified diet. It contained conflicting information by indicating a pureed diet, soft things and small, cut up meats. In addition, Resident 6's ISP was silent to dietary considerations to meet his/her needs for diabetes management. The meal on 04/25/2024 was high in sugar and carbohydrates. Resident 6 was not offered alternatives and Caregiver O said residents are all routinely served the same food even if they have diagnoses of diabetes. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medications N0400 DHS 83.37(1)a) Written Orders for Medications, Supplements. N0415 DHS 83.37(2)(d) Documentation of Medication Administration Y3244 CH 50.09(1)(L) Care	N 389		

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 04/30/2024

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 400	83.37(1)(a) Written order for medications, supplements. Practitioner ' s order. There shall be a written practitioner ' s order in the resident ' s record for any prescription medication, over-the-counter medication or dietary supplements administered to a resident. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure there was a written practitioner's order for 2 of 2 medications reviewed for Resident 1. Findings include: On 04/25/2024 at 2:03 PM, Surveyor reviewed Resident 1's medications and medication administration record (MAR) with Caregiver O. Surveyor noted two medications were added to the MAR in April; estradiol cream administered daily since 04/02/2024 and Myrbetriq administered daily since 04/03/2024. Surveyor observed the Myrbetriq did not have a label from the pharmacy to identify the resident name, instructions, expiration date and prescriber. Caregiver O showed Surveyor the small box came from a larger box in a different drawer of the medication cart. The larger box had Resident 1's first name and "7 AM" written on it with a marker. Surveyor asked Caregiver O for the medication	N 400		

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 04/30/2024

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 400	Continued From page 39	N 400		

orders for the estradiol cream and Myrbetriq. Caregiver O was unable to locate the orders.

On 04/25/2024 at 4:54 PM, Surveyor sent an email to Administrator T and requested medication orders signed by the practitioner for the 2 medications.

On 04/26/2024, Administrator T emailed Surveyor and wrote, "The Myrbetriq was confirmed to be on [his/her] current med list (attached) from Urology 4/2/24. However, I am still waiting for the fax to come from the provider to send over to you. I did not locate any signed order in the building for the Myrbetriq I only confirmed with the provider...and attached is a copy of the order for the Estradiol [sic] sent from [pharmacy]." Surveyor noted the pharmacy faxed the order to the provider on 04/26/2024.

On 04/30/2024, Administrator T emailed Surveyor a visit summary dated 04/02/2024 from Physician's Assistant N. The document was faxed to the provider on 04/30/2024 and read, " ...We will also do a trial of Myrebetriq, samples were provided today, proper administration (and) adverse effects medication reviewed. Medication Changes As of 4/2/2024 10:45 AM...Mirabegron ER (Myrbetriq) 50 MG tablet - 0 refills - Start Date 4/2/2024 End Date 4/26/2024 - Take one tablet by mouth once daily...Notes to Pharmacy: Per order from [Physician Assistant N] on 04/02/24 patient was given Mybetriq from Medication Assistance Program." Surveyor noted the document was not signed by Physician Assistant N.

The email also included Resident 1's April MAR which showed Mybetriq continued be administered 04/27 - 04/29/2024.

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 04/30/2024

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

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N 400	Continued From page 40 On 04/30/2024 Surveyor interviewed Administrator T. S/he acknowledged the 04/02 documentation provided to Surveyor was not a signed practitioner's order and explained it was all s/he could obtain. Administrator T said s/he did not have clarification on the whether the medication was a trial that was supposed to end on 04/26/2024 and would follow with Physician Assistant N's office for clarification. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medications N0400 DHS 83.37(1)a) Written Orders for Medications, Supplements. N0415 DHS 83.37(2)(d) Documentation of Medication Administration Y3244 CH 50.09(1)(L) Care	N 400		
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.	N 415		

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 04/30/2024

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 415	Continued From page 41	N 415		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the accurate documentation of medication administration.

On 02/06/2024, Caregiver F documented 12 units of insulin was administered to Resident 4 as prescribed, when Caregiver O had actually administered 100 units in error.

On 04/24/2024 at 8:00 PM, Resident 1 did not receive scheduled estradoil cream because the caregivers could not locate the medication. A different caregiver subsequently documented the medication was administered as scheduled.

Findings include:

RESIDENT 4
The Department received a self-report from the provider describing a medication error on 02/26/2024 at 5:30 PM. The report indicated Caregiver O administered 100 units of Humalog to Resident 4 instead of the prescribed 12 units. Resident 1 was sent to the emergency room for treatment.

On 03/06/2024, Administrator A emailed documentation from Resident 4's record including the February 2024 medication administration records (MAR). The MAR documented the prescribed 12 units of Humalog was administered at 5:00 PM on 02/26/2024 and the initials of the caregiver who administered the medication did not match those of Caregiver O.

On 03/11/2024, Surveyor emailed Administrator A

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 04/30/2024

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

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N 415	Continued From page 42	N 415		

and wrote, "...On 2/26 (the day of the med error) the MAR documented Humalog was administered at 5pm. It appears the initials are [not Caregiver O's]. The documentation you sent indicated [Caregiver O] was responsible for the medication error. Can you provide information about why the MAR shows different initials?"

Administrator A replied, "... When the med error occurred [Caregiver O] ...was pretty shooken up for not looking closer at the mar ... and [Caregiver F] took over the medication cart the rest of the shift. [Caregiver F] must have signed that med out instead of [Caregiver O]" [sic - all] Administrator A did not describe any steps s/he took to address the inaccurate documentation.

RESIDENT 1
On 04/25/2024 at 2:03 PM, Surveyor reviewed Resident 1's medications with Caregiver O. Caregiver O showed Surveyor Resident 1's April 2024 MAR which listed estradiol cream as a prescribed medication daily at 8:00 PM, however Caregiver O could not locate the medication in the cart. While looking for the medication, Caregiver F and Caregiver V arrived for their shift (2nd shift, 2:00 PM - 10:00 PM) They both stated they couldn't find the medication the previous day during 2nd shift either. Surveyor reviewed the MAR with all 3 caregivers and on 04/24/2024, the medication was initialed as administered at 8:00 PM. Caregiver F and Caregiver V confirmed they were the only 2 that worked 2nd shift and they did not administer the medication. The initials were not legible, but Caregivers F and V thought maybe they belonged to a 3rd shift staff member.

Caregiver V said s/he was responsible for the medication pass the previous day and when s/he could not locate the medication s/he left the MAR

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 04/30/2024

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 415	Continued From page 43	N 415		

entry blank. Caregiver V explained s/he should have circled the entry on the MAR to indicate it was not given and then written an explanation on the back of the MAR. S/he also said s/he should have followed up to report the medication could not be located so it could be re-ordered.

At 2:11 PM, Caregiver F informed Surveyor s/he located the medication in Resident 1's unlocked dresser drawer in his/her room. S/he acknowledged all prescribed medications should be locked in the medication cart and s/he did not know how long the medication had been stored in the room.

Surveyor noted during an interview earlier the same day with Caregiver O at 12:44 PM, s/he said when residents go to medical appointments or when sent they are sent out via ambulance for emergency treatment, their process is to send the MARs with the resident so the receiving provider is aware of the medications prescribed and administered. Based on the 2 aforementioned examples, the MARs were not an accurate representation medication administration.

"Documentation of current medications in the medical record facilitates the process of medication review and reconciliation by the provider, which is necessary for reducing ADEs [Adverse Drug Events] and promoting medication safety. The need for provider to provider coordination regarding medication records, and the existing gap in implementation, is highlighted in the American Medical Association's Physician's Role in Medication Reconciliation, which states that "critical patient information, including medical and medication histories, current medications the patient is receiving and taking, and sources of medications, is essential to the delivery of safe

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 04/30/2024

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

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N 415	Continued From page 44 medical care. However, interruptions in the continuity of care and information gaps in patient health records are common and significantly affect patient outcomes" (2007, p.7). This is because clinical decisions based on information that is incomplete and/or inaccurate are likely to lead to medication error and ADEs. Weeks, Corbette, & Stream (2010) noted similar barriers ..." source: https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_130_MIPSCQM.pdf, retrieval date 04/29/2024 Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medications N0400 DHS 83.37(1)a) Written Orders for Medications, Supplements Y3244 CH 50.09(1)(L) Care	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 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	N 416		

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 04/30/2024

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 416	Continued From page 45	N 416		

provider did not ensure administration of injectables was delegated to a non-licensed caregiver in accordance with the Nurse Practice Act, N6.03(3). Caregiver O was responsible for injecting insulin. The only documentation delegation by a registered nurse (RN) was on 02/19/2020 from a different period of employment. Regional RN D delegated the task in 2020 but did not provide direction, assistance, monitoring or evaluation of Caregiver O after the re-hire date of 01/15/2024. On 02/26/2024, Caregiver O administered more than 8 times the prescribed amount of insulin to Resident 4.

Findings include:

The Department received a self-report regarding a medication error. On 02/26/2024 Caregiver O administered 100 units of insulin subcutaneously to Resident 4 instead of the prescribed 12 units.

Upon request on 03/07/2024, Administrator A emailed Surveyor documentation to show Caregiver O was delegated by a registered nurse to administer injectables. The document was signed and dated by Caregiver O and Regional RN D on 02/19/2020.

The staff roster provided by Administrator A on 02/27/2024 documented Caregiver O's hire date was 01/15/2024, nearly 4 years after the RN delegation.

During an interview with Administrator A and Regional RN D on 03/13/2024 at 8:30 AM, they stated the following:
Administrator A said Caregiver O was a potential hire in February 2020, but was not actually hired until July 2020. S/he was terminated on 03/10/2021. Nearly 3 years later on 01/15/2024

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 04/30/2024

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

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N 416	Continued From page 46 s/he was re-hired. New RN delegation was not completed. Regional RN D said s/he has been responsible for a different region and was only reassigned to this building in recent days. Regional RN D commented, "I have not been here for 3 years, consider me new." Regional RN D did not have an independent memory of the delegation from 2020 and said s/he wouldn't be able to "pick [Caregiver O] out of a line up." Regional RN D said generally, s/he would complete new delegation if employment was separated for more than 12 months and acknowledged delegation 4 years ago was not valid. Regional RN D said s/he oversees at least 14 facilities. After caregivers are delegated under his/her license, "MAR audits may get delegated to me" but supervision falls on the administrator of the facility. Regional RN D stated, "I cannot be in all the buildings at one time." Nurse Practice Act - N 6.03(3) Standards of practice for registered nurses. Supervision and direction of delegated acts. In the supervision and direction of delegated acts an R.N. shall do all of the following: (a) Delegate tasks commensurate with educational preparation and demonstrated abilities of the person supervised. (b) Provide direction and assistance to those supervised. (c) Observe and monitor the activities of those supervised. (d) Evaluate the effectiveness of acts performed under supervision. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures	N 416		

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 04/30/2024

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 416	Continued From page 47 Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medications	N 416		
{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 ensure a daily activity program to meet the interests and capabilities of residents or encourage/promote participation in activities. The provider had a posted activity calendar but did not implement it. This is a repeat deficiency. See SOD YU9214, dated 08/16/2023. Findings include: On 02/27/2024 Surveyor observed the posted	{N 427}		

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 04/30/2024

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 427}	Continued From page 48 activity calendar. The listed activities were: 02/27/2024: bend and stretch coffee social Golden Girls show soft music hand massages evening social 02/28/2024: Sittercises coffee social game show network word search evening social Surveyor was onsite a portion of the day on 02/27/2024 and most of the day on 02/28/2024. Surveyor did not see staff engaging residents in activities. On 10/28/2024 at 10:20 AM, Surveyor observed a group of 6 residents in the dining room and a game show was on the television. Three residents were intermittently looking at the TV Two residents were positioned facing away from the TV and staring into space. One resident was positioned facing away from the TV and was sleeping with his/her head resting on the table. Caregiver P was seated next to the TV completing charting. Surveyor observed for 5 minutes and Caregiver P did not engage at all with the residents. On 02/27/2024 at 12:02 PM, Surveyor interviewed Resident 5and asked if activities were offered. S/he replied, "Not really. I've seen some [guy/gal] in here twice...They played bingo and put together a puzzle." Resident 5 said most of	{N 427}		

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 04/30/2024

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 427}	Continued From page 49	{N 427}		

the residents in the building are too confused to play games or put together a puzzle.

On 02/28/2024 at 10:07 AM, Surveyor interviewed Resident 2 and asked if activities were offered. S/he replied, "Oh no and [expletive] no! I see that on the board sure but I have yet to see any sort of crowd sitting at the table playing cards or playing the board game. The one young [man/woman] that works for the corporation, I haven't seen [him/her] over here except for the once. [S/he] is the activity [guy/gal]." Resident 2 talked about how s/he missed his/her dogs and would enjoy an activity where dogs visited. Surveyor read out loud each of the 6 items on the activity calendar from the day before and asked Resident 2 if they were offered. Resident 2 said no to each one and laughed out loud when Surveyor asked if s/he received a hand massage.

On 02/28/2024 at 10:26 AM, Surveyor interviewed Caregiver Q. S/he also said there was a new activity staff hired "but I haven't see [him/her] often. [S/he] started and then went on vacation and was gone forever so I thought [s/he] wasn't working anymore and then showed up again...I saw [him/her] 2 times last week, before that I don't really know." Caregiver Q said s/he does not have time to do activities and agreed the previous day none of the 6 listed activities occurred.

Surveyor interviewed Administrator A on 03/13/2024 at 8:30 AM. Administrator A said Activity Staff U was hired 10/16/2023 and would come in twice a week. However, s/he was off 3 weeks over Christmas and then in the past 2 weeks s/he removed Staff U from the schedule because Staff U had not completed all required training due mid-January. Surveyor shared

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 04/30/2024

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 427}	Continued From page 50 his/her findings about activities and Administrator A did not dispute them. S/he commented caregivers "have time" and should be providing activities. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations	{N 427}		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on observation, record review and interview the provider did not ensure Resident 1 received adequate and appropriate care within the capacity of the facility in the areas of toileting assistance, health monitoring and safe ambulation.	Y3244		

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 04/30/2024

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
Y3244	Continued From page 51 On 02/27/2024 Resident 1 was heavily incontinent of urine during the overnight hours and the incontinence pad on the bed was damp with urine. Caregiver M assisted Resident 1 to the toilet, changed the brief and then returned Resident 1 to bed without replacing the soiled incontinence pad. Between March and April 2024, the provider did not communicate with Resident 1's physician to ensure an order for a urinalysis was satisfied and subsequently did not notify the physician after Resident 1 displayed signs and symptoms of a urinary tract infection. Resident 1 needed a walker for ambulation and was at risk for falls. On 04/24/2024, Caregiver G observed Resident 1 ambulate 4 times without the walker and did not intervene to remind or encourage Resident 1 to use the walker. Findings include: The Department received a complaint alleging concerns with 3rd shift staff. EXAMPLE 1 On 02/27/2024 at 5:04 AM, Surveyor accompanied Caregiver M to Resident 1 to see if s/he needed toileting assistance or incontinence care. Caregiver M opened Resident 1`s door and turned on the overhead light. Surveyor asked Caregiver M for confirmation this is normally how s/he performs checks during 3rd shift and s/he said it was. Caregiver M abruptly woke Resident 1 and said it was time to go to the bathroom. S/he provided stand by assistance while Resident 1 got out of bed and walked to [his/her] bathroom. Surveyor observed Caregiver M remove the incontinence brief which was soaked and heavy	Y3244		

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 04/30/2024

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
Y3244	Continued From page 52	Y3244		

with urine. While Caregiver M was cleaning Resident 1, Surveyor observed Resident 1's bedding. A blue, cloth incontinence pad was on top of the fitted sheet; it was damp and smelled of urine. When Caregiver M and Resident 1 exited the bathroom, Resident 1 was wearing a new brief and no bottoms. Caregiver M said "[s/he] had quite a bit of urine to get off [him/her]" and that is why s/he didn't put the pajama bottoms back on; s/he did not say why s/he did not put clean bottoms on. Caregiver M assisted Resident 1 into bed on the damp incontinence pad, covered him/her with the blanket and left the room.

Caregiver M told Surveyor Resident 1 was last checked 2 or 2.5 hours ago but s/he did not document the check. Surveyor pointed out the concern that s/he assisted Resident 1 back in bed without checking or changing the damp incontinence pad. Caregiver M replied, "Oh, OK."

On 02/27/2024 at 11:46 AM, Surveyor interviewed Resident 1. Surveyor asked how things are going at the facility and s/he replied, "not very well...staff are not very good." Surveyor asked if caregivers help him/her go to the bathroom at night and s/he replied, "No. I have to wait until morning to go to the bathroom and that's when everything is full of pee...I can't get up alone, I'll fall...they're not that nice to me, I don't know why. I don't do nothing." Resident 1 said, "I don't like [Caregiver M] at all... [s/he] is mean to me."

Surveyor reviewed portions of Resident 1's facility record on 03/06/2024. Resident was admitted on 01/09/2023, was elderly with an activated power of attorney for health care. Diagnoses included bipolar disorder, schizophrenia and dementia. According to the individual service plan (ISP)

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 04/30/2024

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
Y3244	Continued From page 53	Y3244		

dated 02/14/2024, s/he ambulated with a walker and required staff assistance with toileting every 2 hours. Resident 1 was described as "very pleasant...friendly...sweet...can make needs known" The ISP did not document any history of Resident 1 refusing toileting, incontinence checks or other activities of daily living.

Surveyor reviewed charting of bowel and bladder action for February 2024. Resident 1 was incontinent 28 of 29 nights.

On 02/28/2024 at 2:14 PM & 3:56 PM, Surveyor interviewed Administrator A and RN C and on 03/13/2024 at 8:30 AM, interviewed Administrator A.

Administrator A stated:
There are ongoing concerns with the work performance of caregivers and acknowledged s/he has not been effective in correcting it. S/he has received complaints from 1st shift that 3rd shift was not performing incontinence care but s/he put part of the blame on 1st shift for not doing their checks right away. Administrator A said s/he did not conduct or document an investigation into the concerns and did not increase supervision of staff during 3rd shift. Staff are "lazy" and s/he has provided re-education, written reminders on a whiteboard and worked the floor with caregivers. The plan moving forward is to issue written warnings and fire staff after the 3rd warning.

RN C stated:
Their process is not to turn on bright lights and abruptly wake residents during overnight incontinence checks or when offering toileting. S/he described Surveyor's observation as a dignity concern, especially when Resident 1 was

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 04/30/2024

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
Y3244	Continued From page 54	Y3244		

not provided a clean pajama bottoms or a dry incontinence pad.
"I've never seen a team go backwards."

Surveyor interviewed Caregiver O during a return visit on 04/25/2024 at 12:44 PM. Caregiver O said up until 1 month ago s/he worked 3rd shift and s/he would offer Resident 1 toileting assistance every 2 hours. S/he said most of the time Resident 1 would get up and use the toilet. Surveyor asked if s/he thinks other 3rd shift staff consistently provide the same care to Resident 1 and s/he replied, "No. I'm on 1st (shift) now and I've experienced walking in at 6am and people are wet up their backs." Caregiver O said s/he reported the concerns to Administrator A several times but it persists "as recently as yesterday." Caregiver O said Resident 1 is usually heavily incontinent after Caregivers I and J work 3rd shift.

Surveyor reviewed Resident 1's "nursing notes" (caregiver charting) on 04/25/2024. Surveyor noted 4 of 5 times when Resident 1 was found incontinent by 1st shift, Caregivers I or J worked 3rd shift the preceding night:
04/01 3rd shift: "amazing with 2 hour checks." - Caregiver J
04/02 1st shift: incontinent of urine and bowel and was agitated about the incontinence. Given an "emergency shower" and bedding was changed.
04/03 3rd shift: "bad mood...refused to get checked and to use the toilet." - Caregiver J
04/04 1st shift: "incontinent of urine."
04/07 3rd shift: "did not like the light being on and did not want to get out of bed..." Caregiver J
04/08 1st shift: incontinent of urine
04/21 3rd shift - "asleep all night" - Caregiver I
04/22 1st shift - incontinent of urine and bowel.
04/22 3rd shift: "checked on every 2 two hours...refused to go the bathroom." - Caregiver I

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 04/30/2024

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
Y3244	Continued From page 55 04/23 1st shift: incontinent of urine and "complaining" s/he was "sitting in" his/her own urine. Was "very upset, crabby in beginning of the shift." Given a shower and bedding changed. Surveyor also conducted a follow-up interview with Resident 1 on 04/25/2024 at 12:26 PM and asked if there had been improvement with overnight toileting assistance since February. S/he replied, "No. I go on my own...They stopped asking me. I gotta hurry...otherwise, half the time that's when the blood starts coming." (see Example 2) EXAMPLE 2 On 04/25/2024 at 12:01 PM after using the bathroom, Resident 1 approached Surveyor and said there is a lot of blood in his/her urine and s/he has been going frequently. During a follow up interview at 12:26 PM, Resident 1 re-iterated s/he has been having urinary problems including frequent urination, blood in the urine and burning during urination. S/he said it's been going on for "a couple months" and s/he has told staff. Resident 1 said, "These people over here is not getting me a doctor. Can you try to find a way for me to get a doctor?" [sic - all] Surveyor observed Resident 1 was distressed while talking about the concerns. On 04/25/2024 at 1:49 PM, Surveyor interviewed Caregiver O. Caregiver O said the urinary problems were a known issue and Resident 1 was prescribed scheduled medications in early April to treat the problems. Caregiver O showed Surveyor the medication administration record (MAR) and the medications in the cart. The medications started on 04/02/2024 and were Myrbetriq (typically prescribed for overactive bladder) and a hormone cream to be applied to	Y3244		

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 04/30/2024

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
Y3244	Continued From page 56	Y3244		

the urethral area. Caregiver O was unsure why the medications were prescribed or what their purpose was and stated, "I want to say for a yeast infection, maybe a UTI...[s/he] was having them very often." Caregiver O looked for documentation of a medical visit that may have prompted the orders for the 2 new medications, but s/he could not locate it.

On 04/24/2024 at 2:31 PM, Surveyor interviewed Administrator T. Administrator T said Administrator A abruptly separated employment on 04/20/2024 and s/he (Administrator T) was present to provide temporary coverage. Administrator T said the only documentation s/he could find about urinary concerns was a "Physician Visit Form" dated 03/12/2024. This is a facility form sent with residents to appointments. The form documented the purpose of the visit included "chronic UTIs" and "UA/UC (urinalysis with culture) pending." Physician's Assistant (PA) Y signed and dated the form 03/12/2024. Administrator T said s/he would follow up to determine the results of the UA.

On 04/25/2024 at 4:38 PM, Administrator T emailed Surveyor and wrote, "Attached is the office visit summary from 3/12/24 for [Resident 1]. It states that if [his/her] UA/UC came back positive they will treat. There was not any medication orders in the March MAR for treatment of UTI. I assuming [his/her] UA/UC was then negative for UTI." [sic-all]

On 04/29/2024 at 10:58 AM, Surveyor conducted a follow up interview with Administrator T who described the actions s/he took while at the facility on 04/26/2024:
interviewed Resident 1 who reported urinary concerns consistent with what s/he told Surveyor

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 04/30/2024

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
Y3244	Continued From page 57	Y3244		

talked with a caregiver who confirmed Resident 1 had blood in his/her brief on 04/26/2024
put in a request to Resident 1's physician for an appointment, but s/he was no longer covering at the facility so s/he did not know if the physician called back.
searched the facility for documentation of an after visit summary (AVS) from 03/12/2024 but did not find one. S/he stated that was concerning because AVSs provide "super important" information about diagnoses, new care needs, medications, referrals and/or follow up visits.
asked the physician's office about the 03/12/2024 UA/US order and was told there were "no results."

Surveyor asked Administrator T if s/he took steps to confirm whether a urine sample was actually taken and tested, and s/he said s/he had not. Administrator T again said s/he would follow up.

On 04/30/2024 at 4:33 PM, Surveyor conducted another interview with Administrator T. S/he said after further communication with PA Y's office, s/he determined a urine sample was not taken after the 03/12/2024 visit. S/he explained the language on the visit form about the "pending" UA/UC was unclear and that likely caused the mistake. Administrator T did not describe any efforts by former Administrator A or other facility staff to get clarification from PA Y on whose responsibility it was to collect the sample. Administrator T determined Resident 1 was seen by urology on 04/02/2024 and during that visit a UA was not ordered.

Administrator T explained today, PA Y's office ordered another UA/UC based on Resident 1's symptoms. Administrator T determined the facility had supplies and a process to collect and

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 04/30/2024

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
Y3244	Continued From page 58 submit samples, which Caregiver O did today. The preliminary test results were "suspicious" for a UTI and an antibiotic was prescribed to treat it pending results of the culture. EXAMPLE 3: During the aforementioned record review of Resident 1's ISP updated 08/14/2024, Surveyor noted a section titled "Safety Concerns" which identified him/her as a "fall risk." The section titled "Mobility" read, "Needs to use walker, has been unsteady on [his/her] feet." On 04/25/2024, Surveyor made the following observations of Resident 1 ambulating without his/her walker: At 11:55 AM, Resident 1 stood up from the lunch table and announced s/he was going to use the bathroom. S/he walked away without taking the walker that was next to him/her, and returned at 12:00 PM. At 12:01 PM, Resident 1 walked from the lunch table, across the dining room to Surveyor without using the walker, then ambulated back to the lunch table. At 12:26 PM, Resident 1 stood from the lunch table to join Surveyor in his/her room for an interview. Resident 1 started to walk from the table without the walker. Surveyor asked Resident 1 if s/he needed the walker, s/he agreed s/he did and used it to ambulate his/her room. At 12:34 PM, Resident 1 was walking down the hall without his/her walker. During all 4 of the observations, Caregiver G was present and did not intervene to offer a reminder to Resident 1 about the walker or provide stand by assistance.	Y3244		

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 04/30/2024

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

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Y3244	Continued From page 59 On 04/25/2024 at 1:49 PM, Surveyor interviewed Caregiver G. Caregiver G said this is not "[his/her] building" and s/he is primarily assigned to building 1 (sister facility across the parking lot.) Caregiver G said s/he has been working as a "float" and providing cares regularly in this building for approximately a month and today was the first time s/he was scheduled for a full day shift in the building. Caregiver G said s/he has not read ISPs or been otherwise trained in the residents' care needs. S/he commented, "I'm not comfortable in this building. The only people I know here are [Resident 4 and 6]. I was trained for one day." Caregiver O was present during the interview confirmed Caregiver G's statements. S/he acknowledged caregivers are not thoroughly cross trained on resident care needs even though they are required to provide coverage between buildings. On 04/25/2024, Surveyor reviewed Resident 1's ISP located in the medication room. Surveyor noted the ISP was not the most current version that had been provided to Surveyor by Administrator A on 03/06/2024. The version in the medication room that was available to caregivers was from 2023 and read, "Mobility - Can walk independently, has a walker that [s/he] hasn't been using." The ISP had a sheet of caregiver signatures to indicate their review of the ISP and Caregiver G's signature was not on the list. On 04/29/2024, Surveyor interviewed Administrator T. Administrator T said s/he also noticed the former administrator kept the current ISPs and most resident records in the office in building 1 and said it was not a good practice.	Y3244		

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 04/30/2024

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
Y3244	Continued From page 60 Administrator T said on evenings and weekends the building 1 office is locked and access limited to the 2 assistant directors from each building. Administrator T also said on 04/26/2024 s/he spent time talking with Resident 1 and reviewing his/her record. Administrator T described Resident 1 as easily re-directable and with some ability to remember, retain and accurately report information. Administrator T said reminders to use the walker had the potential to be effective for Resident 1. Cross Reference: N0161 DHS 83.12(3) Investigate Injuries of Unknown Source N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medications N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0400 DHS 83.37(1)a) Written Orders for Medications, Supplements. N0415 DHS 83.37(2)(d) Documentation of Medication Administration	Y3244		