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	0011954	A. BUILDING: _____ B. WING _____	R-C 11/06/2024

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

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{N 000}	Initial Comments On 10/22/2024, Surveyor conducted an onsite visit at Care Partners Stevens Point 2 to investigate 3 complaints, review 1 self-report and conduct verification visits for SOD NCQ011, dated 06/10/2024 and SOD YU9Z15, dated 04/30/2024. Return visits were conducted on 10/23/2024 and 10/24/2024 and additional information was received through 11/06/2024. Three (3) of 3 complaints were substantiated. One (1) of 1 deficiency from SOD NCQ011, was uncorrected. Seven (7) of 11 deficiencies from SOD YU9Z15, were uncorrected. A total of 11 new deficiencies were identified. Census: 1 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}		

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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 interview and record review, after receiving allegations of caregiver misconduct, the provider did not take immediate steps to ensure the safety of all residents and did not conduct or document thorough investigations within 7 days to determine if the incidents required reporting to the Office of Caregiver Quality (OCQ). On 10/19/2024 at 10:29 PM, Director A received an allegation Resident 8 was neglected. Director A did not take immediate steps to determine all caregivers who may have been involved in the neglect incident and did not begin his/her investigation until 10/21/2024. Director A did not document all investigative steps, did not interview Resident 3 who may have been impacted by or witnessed the incident and did not conduct or document a thorough interview with Resident 8. While the matter was pending, on 10/20/2024 and 10/22/2024, Caregiver Y worked alone with Resident 8. It was subsequently determined Caregiver Y was involved in the 10/19/2024 incident and on 10/23/2024 the provider terminated his/her employment. On 10/04/2024, Caregiver J made a written complaint alleging the following; when s/he relieved Assistant Director K from his/her shift, Residents 4 and 8 were both soaked in urine and dry feces; Resident 3's medication was not administered and a blood sugar check was not	{N 158}		

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

done for Resident 4; Assistant Director K left the building unattended to smoke outside. Director A did not take immediate steps to protect residents and did not investigate the allegations to determine if neglect occurred that required reporting to OCQ. As of 10/22/2024, Assistant Director K continued to work unsupervised providing care to residents.

This is a repeat deficiency being cited for the fourth time. See Statement of Deficiency (SOD) YU9Z11, dated 09/01/2022; SOD YU9Z14, dated 08/16/2023; SOD YU9Z15, dated 04/30/2024.

Findings include:

The Department received a complaint alleging neglect of a resident on 10/19/2024.

Surveyor interviewed Director A on 10/22/2024 at 10:25 AM. Director A said s/he had not investigated any allegations of caregiver abuse or neglect since the last survey in June 2024, but s/he was completing an investigation related to an incident that occurred on 10/19/2024 involving Caregiver Z. Director A stated it is his/her responsibility as the director to conduct the investigations, along with assistance from the regional office. Director A also said the only 2 residents living at the facility on 10/19/2024 were Resident 3 and Resident 8. Director A referred to the building as the "memory care."

Surveyor reviewed the provider's Abuse and Misconduct Policy (dated 12/12/2012) on 10/24/2024 which read in part, "It is the policy of Care Partners to assure the protection of each resident from possible abuse ...all people deserve dignified, loving care with services provided to maximize their potential for living and

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{N 158}	Continued From page 3 independence ....All employees ...are required to immediately report any known or suspected abuse to the Director ...Director will contact the Corporate Office to assist in the investigations. All reports of actual or alleged misconduct must be reported to the Department of Health Services on (misconduct incident report form) within seven (7) working days after the initial report ...DEFINITIONS ...'Abuse' means any of the following, if done intentionally. An act, omission or course of conduct by another that is not part of a treatment plan ...and does any of the following ...intimidates, humiliates, threatens, frightens, or otherwise harasses a resident ...Substantially disregards a resident's rights ...or a caregivers duties and obligations to a resident ...'Neglect' means an act, omission or course of conduct by a caregiver ...that is due to such substantial carelessness or negligence of the caregiver's duties and obligations to the resident as to create a significant danger to the physical or mental health of a resident ...." Surveyor reviewed the provider's plan of correction (POC) documentation for SOD YU9Z15, provided by Director A on 10/24/2024. It read in part, "[Regional Manager P]: Come up with policy/cheat sheet on how to do a proper investigation." The associated investigation cheat sheet defined situations that warrant investigations to include allegations of "abuse, misconduct, appropriations [sic]...Steps to a proper investigation ...record the timeline of events...what time you took immediate steps...etc., Notify [Regional Manager P] and [Administrator H]...Suspend employees involved if needed...Gather written statements of everyone involved with date and signature...Interview resident(s)...Work on a conclusion."	{N 158}		

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{N 158}	Continued From page 4 Surveyor reviewed the Department's Caregiver Program Manual, a resource for providers last revised 10/2024. It read in part, "ENTITY INTERNAL INVESTIGATION RESPONSIBILITIES - Protection of Clients - Immediately upon learning of the incident, the entity must take necessary steps to protect clients from possible subsequent incidents of misconduct or injury ... All entities regulated by DQA must conduct a thorough internal investigation and document the findings for all allegations or incidents at the entity. A thorough internal investigation may include: Collecting and preserving any physical and documentary evidence including videos; Interviewing alleged victims and witnesses; Collecting other corroborating/disproving evidence; Involving other regulatory authorities who can assist ...e.g., local law enforcement ...; and Documenting each step taken during the internal investigation. These steps should be taken as part of the entity's initial attempt to determine what, if anything, happened and to determine the complete factual circumstances surrounding the alleged incident. An entity's internal investigation will assist in determining if an incident must be reported to DQA (Office of Caregiver Quality) ..." EXAMPLE 1 Surveyor reviewed Stevens Point Police Department report C24-11464. The report detailed an incident on 10/19/2024. Beginning at 9:44 PM, Caregiver Z made calls to 911. S/he ultimately stated s/he was drunk and needed a ride home. During one of the calls dispatch could hear someone in the background yelling. Caregiver Z explained s/he was "in the room with a dementia patient who had gotten stuck in their chair after falling...[Caregiver Z] believed [s/he] would need help but was able to get the patient	{N 158}		

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{N 158}	Continued From page 5 up..." When officers made contact with Caregiver Z at the facility, s/he said s/he was administering the last of the evening medications. However, Caregiver Y was also present and told officers s/he'd already administered the medications. The officers determined Caregiver Z was intoxicated and Resident 8 was found covered in feces. Caregiver Z was arrested on charges of neglect. Surveyor noted the police investigation focused on Resident 8's neglect and it was unclear if Caregiver Z's statements about a resident falling were related to Resident 3 or Resident 8. During follow up investigation by Detective R on 10/21/2024, s/he requested time sheet documentation from Director A which indicated on 10/19/2024 Caregiver Y worked 2:00 PM - 9:45 PM and Caregiver Z clocked in at 8:45 PM with no clock out time. S/he also determined Caregiver Y worked the following day 10/20/2024 from 1:45 PM to 6:00 PM. Surveyor interviewed Director A on 10/22/2024 at 10:25 AM and Regional Manager P joined at approximately 10:30 AM. Director A said s/he received an allegation of caregiver misconduct from the police impacting Resident 8 on Saturday 10/19/2024 at 10:29 PM. The police informed Director A Caregiver Z had called 911 several times resulting in police response. Officers found Caregiver Z very intoxicated and found Resident 8 "full of feces." Director A said, the officer "told me they were pressing charges on their end of neglect and what we do is up to us." Director A said s/he did not start his/her investigation until Monday morning 10/21/2024 at 7:35 AM. S/he "talked with" Resident 8 that morning while Resident 8 was eating and said	{N 158}		

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{N 158}	Continued From page 6 Resident 8 was "vague about everything, [s/he] was blah about it. [S/he] didn't have much to say" other than to say s/he felt uncomfortable when the police took photos of him/her and s/he was "upset and crabby when [s/he] was being cleaned up." S/he said it hurt because some of the feces was dried. Director A described the talk as a general "overview" of how things have been going and was not focused on the incident that occurred on 10/19/2024. Director A said s/he did not document the talk with Resident 8. Director A stated his/her investigation was complete except s/he was "just waiting for [Caregiver Y]'s statement." Director A expressed frustration Caregiver Y allowed Caregiver Z to assume care of residents if s/he was intoxicated. Director A said Caregiver Y worked on Sunday 10/20 from 2:00 PM and 6:00 PM and was scheduled to work again today 10/22, during second shift. Director A provided the October 2024 schedule which indicated Caregiver Y was scheduled alone both shifts. Surveyor asked Director A if s/he considered responding to the facility on 10/20 to interview Caregiver Y while s/he was working. Director A responded by saying s/he made one call to Caregiver Y on Sunday, but s/he didn't answer. Director A said s/he did not leave a message or call back because s/he (Director A) went hiking. Director A also stated Resident 3 was present at the time of the incident on 10/19, but s/he did not interview him/her prior to Resident 3's previously scheduled move out on Sunday at 11:00 AM. Director A said the police department said they would provide an update on Sunday 10/20 by 6:00 PM, but they did not and s/he did not contact them to obtain information about the incident. Director A said Detective R arrived onsite 10/21 in the afternoon and prompted Director A to check time sheet records at which point s/he discovered	{N 158}		

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{N 158}	Continued From page 7 both Caregiver Y and Caregiver Z were clocked in from 8:45 PM until 9:45 PM, during the timeframe when Resident 8 was neglected. Regional Manager P said the medication administration records (MARs) were audited and "checked out." (Note: Surveyor subsequently reviewed the MARs for Resident 3 and 8 and found discrepancies.) Director A reiterated the investigation was complete other than Caregiver Y's statement and s/he provided Surveyor with documentation of the investigation on 10/22/2024. The documentation consisted of: Summary document authored by Director A which read in part, "After I had gotten off the phone with the officer I had texted [Administrator H and Regional Manager P]...[Administrator H] ...called and I explained everything...[Administrator H] had said to do the investigation on Monday, ask questions to the last 2 residents, question the staff that were around at the time or who had contact with [him/her] that day, and then to make sure that [Caregiver Z] was terminated, I said oh of course!...I had called the other building to talk with [Caregiver Q] to see if [s/he] had any interaction with [Caregiver Z]...in the little bit of time [s/he] was there (3rd shift)...[s/he] had not...Sunday October 20th...[Regional Manager P] called me at 7:05 am...[Regional Manager P] had said to start my investigation right away on Monday and to make sure that I am asking both residents, staff that were involved or around [Caregiver Z] at the time of the incident... [Assistant Director K] called me at 9:08 am I had asked [him/her] to start asking the 2 residents questions ...I told [him/her] to ask: 'Did you feel Safe?...Did you feel your cares were met?...Did you notice anything off with the staff?...Did anything make you feel uncomfortable?...Was	{N 158}		

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{N 158}	Continued From page 8 any of the staff acting different than normal?...Did you notice what staff was drinking? Could you describe it?...Did anything seem off or odd?' I told [Assistant Director K] that when asking [s/he] had to ask both residents the questions and to make sure that [s/he] is documenting the questions and the answers. I had also asked [Assistant Director K] to please do a body audit on [Resident 8] just to check [him/her] over..." [sic - all] Typed documentation of interviews with Resident 3 and Resident 8 which listed the 5 aforementioned questions and responses. Responses were very brief (e.g. yes, no, sure, I don't know or shrugged shoulders) and follow up questions were not documented. Written statement dated 10/21/2024 authored by Caregiver J, providing his/her observations after police were onsite. Written statement dated 10/21/2024 authored by Caregiver AA, who was working in the sister facility during 2nd shift on 10/19/2024 and describing his/her interaction with Caregiver Z. Termination notice dated 10/21/2024 for Caregiver Z, "[Caregiver Z] showed up to work and called 911 on [him/herself] several times. Cops showed up and [Caregiver Z] was intoxicated (BAC 0.248), cops called me, we had a replacement come in, [Caregiver Z] was arrested on property." Surveyor noted the following: The documentation was silent to any steps taken to protect residents and silent to investigative steps to determine if Caregiver Y had a role in the neglect of Resident 8. The caregiver statements did not indicate an active interview process occurred. Documentation of resident interviews did not identify the date or time of the interviews or who conducted them.	{N 158}		

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{N 158}	Continued From page 9 There was no documentation of Director A's interview with Resident 8 or documentation the MARs were audited. There was no documentation of follow up with the officers that responded onsite 10/19/2024. There was no conclusion of whether neglect occurred. Surveyor interviewed Assistant Director K on 10/22/2024 at 10:00 AM. S/he said Director A asked him/her to talk to Resident 8 during his/her shift on 10/20. S/he said, "I asked [Resident 8] if [s/he] felt unsafe, [s/he] said, 'No.' I asked did you remember the police? [S/he] said, 'Yes' but didn't know why they were there. I asked, 'Did anybody hurt you?' [S/he] said, 'No.'" Assistant Director K said s/he did not attempt to interview Resident 3 based on his/her impression Resident 3 was asleep during the incident. Surveyor showed Assistant Director K the typed documentation of resident interviews provided by Director A, which indicated both Resident 3 and Resident 8 were interviewed. Director K said, "This isn't what I wrote out for [Resident 8]...I asked if [s/he] felt unsafe, did [s/he] remember the police (and) did anybody hurt or harm [her]...that's what I was ask to ask." Assistant Director K also reiterated s/he believed Resident 3 was asleep during the incident and as a result, "I didn't talk to [Resident 3] at all." Surveyor conducted a follow up interview with Director A on 10/24/2024 at 11:00 AM. Surveyor inquired about the documentation of interviews with Resident 3 and Resident 8 and requested a copy of Assistant Director K's handwritten notes. Director A said, "Whatever [s/he] wrote [s/he] slid under my door" and agreed to look. At approximately 11:20 AM Director A said s/he couldn't find the notes. Surveyor explained	{N 158}		

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{N 158}	Continued From page 10 Assistant Director K stated s/he did not interview Resident 3 and did not ask all five questions to Resident 8. Director A did not offer additional information. Surveyor interviewed Caregiver Y on 10/22/2024 at 2:26 PM. S/he stated s/he was working when Caregiver Z arrived between 8:00 and 8:30 PM on 10/19/2024 and provided details about the events that transpired over approximately two hours. Caregiver Y acknowledged s/he did not provide incontinence care to Resident 8 after 6 or 6:30 PM, even though s/he knew Resident 8 had been sick and experienced diarrhea all day. Caregiver Y denied s/he had any missed calls from Director A on Sunday 10/20 and said the first time Director A reached out about the incident was via text message on Monday after 3:00 PM. Caregiver Y showed Surveyor the text which read, "...I do need a written statement from you by tomorrow at 10am for everything that had happened Saturday night and the interaction with [Caregiver Z]." Caregiver Y showed Surveyor the text and the call log from Sunday; Surveyor noted the call log did not include any missed calls from the facility or the number Director A texted from. Surveyor exited the facility on 10/22/2024 at approximately 4:30 PM and observed Caregiver Y was the only caregiver working 2nd shift with Resident 8. Director A and Regional Manager P had already left for the day and only 1 caregiver was working in building 1. On 10/23/2024 at 11:46 AM, Director A and Regional Manager P informed Surveyor they received Caregiver Y's statement via text message and they were suspending him/her. They also acknowledged they did not interview Caregiver Y yesterday when s/he was working and Caregiver Y completed his/her scheduled	{N 158}		

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{N 158}	Continued From page 11 shift. At 2:00 PM, Regional Manager P provided Surveyor with a document titled, "Timeline/Investigation." The timeline did not include evidence of additional investigative steps taken prior to Surveyor's onsite visit on 10/22/2024, it was not signed and the author was not noted. The revised investigation documentation noted efforts on 10/23/2024 to obtain the police report and obtain Caregiver Y's statement along with follow up questions. The documentation did not include evidence Caregiver Y was asked about the care s/he did or did not provide to Resident 8. Caregiver Y was terminated on 10/23/2024 at 1:40 PM. The report ended, "[Regional Manager P] contacted [Administrator H] on 10/23/2024 at 1:36 PM directing [him/her] to file both [Caregiver Y and Caregiver Z] on the caregiver misconduct registry." The documentation did not include a conclusion to indicate why Caregiver Y was being referred for misconduct. On 11/06/2024 at 1:34 PM, Surveyor received a supplemental police report related to the 10/19/2024 incident. Detective R authored the report which concluded, "At this time I am requesting this report to be sent to the DA (District Attorney) to review regarding the original (neglect) charges against [Caregiver Z], along with charges for [Caregiver Y] since they were both working at the time of the incident." EXAMPLE 2: On 10/22/2024 and 10/23/2024, Surveyor observed Assistant Director K working alone in the facility responsible for the care of Resident 8. On 10/24/2024 at 8:26 AM, Surveyor reviewed Assistant Director K's employee record and noted	{N 158}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 158}	Continued From page 12 the following : "Employee Warning Notice" dated 10/08/2024 for the following "violations"; conduct, personal work, insubordination, work quality (complaints of not changing residents) and leaving residents unattended to smoke. "See attached papers". Attached was a portion of the provider ' s abuse policy with the definition of neglect and the following handwritten complaint authored by Caregiver J: 10/04/2024: "When I arrived for my 2PM-10PM shift...when I did rounds I discovered [Resident 4] soaked and had dry BM (bowel movement) on skin and [private] area was extremely red. I continued with rounds and discovered another resident soaked with urine, through the clothes and the bed pad was wet as well. This resident [Resident 8] also had dry bm [sic] on skin and [private] area was red as well. I also noticed [Resident 3] 10 AM med not passed as well. [Resident 4] hasnt [sic] had a b.s. (blood sugar) check charted all month (4th day of the month) I seen [him/her] sitting outside smoking or in [his/her] car smoking leaving facility unattended...This is about [Assistant Director K]." Surveyor interviewed Director A on 10/24/2024 at 8:36 AM and asked about the warning notice. Director A said Caregiver J slid the written complaint under his/her door on 10/04/2024. Then on 10/08/2024 from his/her office in building 1, s/he observed Assistant Director K leave building 2 unattended to go outside to smoke leaving all the residents unsupervised. Director A called Assistant Director K over to building 1 and "talked to [him/her]." Director A told Surveyor, "[S/he]'s been warned about care issues and it's not getting better." Director A said that was the totality of his/her response and documentation	{N 158}		

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{N 158}	Continued From page 13 related to the allegations. 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 N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment	{N 158}		
{N 161}	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record and interview, the provider did not ensure a thorough investigation was completed in an effort to determine the source of injuries sustained by Resident 7. This is a repeat deficiency. See Statement of Deficiency YU9Z15, dated 04/30/2024. Findings include: Surveyor reviewed the provider's plan of correction (POC) documentation for SOD	{N 161}		

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{N 161}	Continued From page 14 YU9Z15, provided by Director A on 10/24/2024. "Investigate Injuries of Unknown Source - Regional Manager P/Director A: How to investigate unknown bruises. Staff Retraining Topics: How to document bruises/body audits. How to report bruises. Describing the bruise. Documenting where the bruise came from if known. Inappropriateness of charting for other people." 07/31/2024 training document signed by Regional Manager P and Director A, "Bruises of Unknown Origin - When a bruise of unknown origin is brought to your attention, follow the procedures below: 1. Document the shape, size, color and placement of the bruise on the Body Audit Form. 2. Call Regional RN and [Regional Manager P] if needed. 3. Interview resident to see if they know the origin. 4. If resident doesn't know...interview staff... If suspected abuse suspend caregiver and begin investigation..." [sic - all] The documentation did not contain evidence of staff training on the topic of documenting or reporting injuries of unknown origin. There was a training topic during a staff meeting on 08/15/2024 which read, "Residents need to have body audits done! After every shower and even after getting them dressed, they need to have body audits done! We need to make sure they have clean and clear skin and if not then we need to take the proper steps to make sure their skin is intact and clear." [sic - all] Surveyor reviewed Assistant Director G, Assistant Director K, Caregiver E, Caregiver L, Caregiver Y and Caregiver Z's staff training records and did not locate evidence of training related to documenting, reporting or investigating injuries of unknown origin. Surveyor reviewed Resident 7's facility record. S/he was admitted 01/17/2023 and discharged	{N 161}		

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{N 161}	Continued From page 15	{N 161}		

10/16/2024. The individual service plan (ISP) dated 07/02/2024 documented Resident 7 ambulated with a walker and needed staff assistance with activities of daily living to include incontinence care every 2 hours and "body audits...on shower days and daily when cares are being done."

Surveyor interviewed Assistant Director K on 10/22/2024 at 12:09 PM. S/he volunteered concerns about bruises discovered on Resident 7 on 10/12/2024. Assistant Director K showed Surveyor a text string initiated by Caregiver J on Sunday, 10/13/2024 at 10:44 PM:
Caregiver J wrote, "I just got home from there (facility). it's been a bad weekend. lots of events have transpired and it's truly unfortunate...complete [expletive] show...there's 3-4 state reportables...resident injuries of a unknown source...[Resident 7 has] bruising all over." [sic - all]
Assistant Director K replied, "Omg!!" [sic].
Caregiver J wrote, "I notified it yesterday when doing cares, i was like wtf." [sic - all]. Caregiver J then sent two photos.
Photo 1: right bicep with 3 yellow/brown circular bruises approximately 1" diameter
Photo 2: right forearm with a large bruise approximately 4" long and spanning the entire width of the forearm. It was dark green on the edges, dark purple moving to the center, red and yellow in the center, and one edge had a small yellow area.
Assistant Director K replied, "[Resident 7] didn't have any fri" [sic - all]
Caregiver J wrote, "I found them Saturday when I was getting [him/her] ready for bed and forgot to report it until tonight cuz of all the [expletive] that happened...I have not worked over there since the 9th...and there is zero charting for any of the

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bruising...so that's why I was like what the [expletive]...honestly everything that happened is very concerning. There's so many ways [s/he] could have got those bruises. State is gonna hit us for this [expletive] for sure." [sic - all]
Assistant Director K replied, "Yes. Fri those were not there."
Assistant Director K said Director A is responsible for investigations but commented, "[Director A] really has not been in this building at all. [His/her] office is over there." Assistant Director K pointed to building 1, the sister facility across the parking lot.

Surveyor interviewed Caregiver Y on 10/22/2024 at 2:26 PM. S/he also expressed concern about the source of the bruising and referred to "fingerprints" when describing the bicep bruises. S/he described the forearm bruise as "massive" and said the bruise on the "inner thigh by the groin (was) nowhere we would have been really touching." Caregiver Y said s/he did not share the concerns with Director A and commented "I've tried before" and concerns weren't resolved.

Surveyor interviewed Director A on 10/23/2024 at 8:33 AM. Director A said it is his/her responsibility to investigate injuries of unknown origin and s/he was retrained on how to conduct them as part of the POC. Surveyor asked if s/he has conducted any investigations since the retraining. S/he replied, "I haven't had to yet...There have not been any injuries of unknown origin I am aware of." Surveyor asked if s/he received a report of Resident 7's bruising. Director A said yes and explained there is an incident report associated with it. Director A said s/he was informed via text message from Caregiver J on Sunday, 10/13/2024 at 8:01 PM, and showed Surveyor the messages:

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Caregiver J wrote to Director A and Assistant Director G, "So [Resident 7] has these huge bruises that I forgot to chart yesterday." Caregiver J sent the same two aforementioned photos.
Assistant Director G replied, "Holy [expletive]. What is [s/he] saying about them"
Caregiver J replied, "[S/he] said it hurts...and on [his/her] right breast, and left leg near [private] area...also really haven't been over here so I don't know when [s/he] got them. what action would you like me to take regarding this? Back chart and fill out an incident report?" [sic - all]
Director A wrote, "Has any resident complained about a staff?"
Caregiver J replied, "[Resident 1] tried telling me something but I couldn't make sense of it..."
Director A wrote, "Did [Resident 7] report a fall of any type?"
Caregiver J replied, "No one reported any falls to me, and nothing is known the charting." [sic - all]

During the interview, Director A provided Surveyor all documentation surrounding the bruising.
"Shower Day Worksheet/Body Audit" form - documented an audit on 10/06 with "0 concerns", author Assistant Director K; a hospice shower documented 10/13 with "No concerns", author unknown; a 10/13 audit with "bruising" on right forearm, right bicep and left groin (breast bruise not charted), author Caregiver J.
Observation notes 10/11-10/13: did not document any falls or incidents that may have caused the injuries.
Observation note 10/12 day shift: "Woke up pretty late today was very sore this morning..."
Observation note 10/13 PM shift: "When doing cares, writer observed bruising on residents right arm, about 4 spots one about 3 inches wide, and others about half an inch wide (small). Resident also has a small bruise on left leg. Resident

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{N 161}	Continued From page 18 stated 'I do not know hows that got there. director, Ad, hospice notified. AD reported to facility." [sic - all] Incident reported authored by Caregiver J - incident occurred 10/13/2024 at 7:14 PM in Resident 7's bathroom. "Writer found bruising when doing PM cares. on right arm multiple spots, and in groin. does not know how happened." [sic- all] A second version of the "Shower Day Worksheet/Body Audit" form documented a shower on 10/01, an audit 10/04 and a shower 10/09. All were authored by Assistant Director K and each documented "no concerns." A duplicate audit was documented on 10/13 by Caregiver J which noted "bruising found" but only the bicep bruising was documented. Handwritten notes authored by Assistant Director G documented interviews with Caregivers M, BB, CC and J. They read in part, "Called [Caregiver BB] who worked AM shift on 10.13.24. AD asked if [s/he] noticed any bruises...[s/he] stated "no"...asked if [s/he] noticed any bruises at all this week and [s/he] said 'no nothing on anyone'...said that [Resident 7] (was) independent on cares." Caregiver CC denied seeing bruising and described Resident 7 as "independent & prompts." Assistant Director G also documented an interview with Resident 7 that read, "...Denies fall, or bumping anything...bruises hurt. Thinks someone hits [him/her] - doesn't know if a [male or female] hits [him/her]." Assistant Director G also documented an interview with Caregiver J who said "Residents were mad at [Assistant Director K] that day, [Resident 1] said [Assistant Director K] was 'mean', which stuck out to [Caregiver J]." Surveyor noted:	{N 161}		

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None of the documentation was authored by Director A and it did not include a conclusion. Caregiver BB and Caregiver CC's statements that Resident 7 was independent with cares were not consistent with the ISP which indicated Resident 7 needed staff assistance every 2 hours with incontinence and daily body audits while providing cares.
Not all caregivers who had cared for Resident 7 in the days preceding 10/12/2024 were interviewed. According to schedules provided by Director A on 10/23/2024, Assistant Director K, Caregiver Z, Caregiver Y and Caregiver DD all worked between 10/09 and 10/12/2024.
The incident report and observation notes did not accurately document that date the bruises were discovered.
Assistant Director G's employee record (reviewed on 10/24/2024 at 2:27 PM) included a job description which did not include responsibilities for conducting investigations and training records did not include evidence s/he received training on conducting investigations.

Surveyor interviewed Caregiver J on 10/23/2024 at 2:36 PM, and Director A was present. Caregiver J recalled discovery of the bruises on 10/12/2024. Caregiver J said s/he asked Resident 7 about them and s/he said..."[s/he] bumped into something. Then it would turn into [s/he] shoved me down, it didn't make any sense." Surveyor asked Director A if s/he was previously informed of the allegations of shoving and s/he said s/he was not.

Surveyor interviewed Director A and Regional Manager P on 10/23/2024 at 9:00 AM. Director A said s/he was unsure which caregiver documented the 10/13/2024 shower provided by hospice and had not followed up on the

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inconsistency with the documentation of "no concerns" on that date when Caregiver J observed bruising on 10/12/2024.

Surveyor conducted a follow up interview with Director A on 10/24/2024 at 11:08 AM and reviewed concerns the observation notes and incident report did not accurately document the date the bruises were discovered, not all caregivers who worked in the days preceding the discovery were interviewed and 2 caregivers gave statements that Resident 7 was independent with cares when the ISP indicated s/he was not. Director A confirmed Resident 7 was not independent with cares and acknowledged Surveyor's review of the records. Director A also acknowledged Assistant Director G's notes documented Resident 7's allegations s/he thinks someone hits him/her and Caregiver J's statement that a resident reported Assistant Director K had been mean. Director A confirmed s/he did not investigate any of the allegations.

Surveyor received records from Hospice Director KK on 10/30/2024:
10/07/2024 visit note: "Cognition: abnormal comprehension, impaired long-term memory, impaired short-term memory, poor problem solving...anxiety, fatigue, forgetfulness, wandering." The narrative read, "Large bruise to right forearm...able to verbalize a few sentences today but then most words are hard to put together into sentences...Staff have no new concerns or needs..." The last documented fall was 08/19/2024.
10/13/2024 call note 8:45 PM: "[Caregiver J] called to update hospice that [Resident 7] had bruising on [his/her] right arm that goes up the arm and has turned dark. Then on [his/her] left leg going to inner groin area...is unsure if the

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{N 161}	Continued From page 21 CNA from hospice saw it today when showering..." Surveyor conduced an interview with Hospice Director KK on 10/30/2024 at 1:24 PM. Director KK stated their record did not include information to explain the source of the bruises. Director KK said other than Caregiver J's phone call on 10/13, their agency had not been contacted by facility staff to discuss concerns about bruising or the shower provided on 10/13. Director KK told Surveyor Resident 7 does have a medical diagnosis that makes him/her prone to bruising, however s/he said their records did not indicate frequent bruising was a concern and stated bruising as described would be concerning and warrant further review. Director KK said s/he would be following up with Director A regarding the concerns. 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 N0408 DHS 83.37(1)(i) PRN Psychotropic Medication	{N 161}		
{N 196}	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by:	{N 196}		

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{N 196}	Continued From page 22 Based on observation, interview and record review Licensee N did not ensure the CBRF and its operation comply with all laws governing the CBRF. --Licensee N did not ensure the facility complied with special orders issued by the Department on 06/07/2024. --Due to quality of service concerns, managed care organization (MCO) S terminated their contract with the provider and relocated 6 residents. --The facility has a demonstrated a pattern of noncompliance with regulations during the past 6 years over the course of 7 surveys. The is a repeat deficiency being cited for the third time. See Statement of Deficiency (SOD) YU9Z13, dated 09/01/2022 and SOD YU9Z14, dated 04/30/2024. 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. ENFORCEMENT ORDERS As a result of the previous survey, YU9Z15 ending on 04/30/2024, the Department issued special orders in a notice dated 06/07/2024. The orders read in part, "Pursuant to Wis. Stat. § 50.03(5g)(b)3., effective immediately, the licensee shall comply with the requirements specified by Wis. Stat. ch. 50 and Wis. Admin. Code ch. DHS 83 that establish the standards for the operation of the Community Based Residential Facility in order to protect and	{N 196}		

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promote the health, safety and welfare of the residents ....
Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b)7., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Care Partners Stevens Point 2 NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations in Statement of Deficiency YU9Z15 are corrected, compliance is verified by the Department, and this Order is rescinded in writing ...
Pursuant to Wis. Stat. § 50.03(5g)(b)6., EFFECTIVE IMMEDIATELY, the licensee shall ensure the provision of services to meet residents' physical and mental health needs. The licensee will correct all identified deficiencies in consultation with a registered nurse (RN) ...
... Consultation will include the development (or revision) of written procedures and staff training (as appropriate) to address ...Caregiver Misconduct ... Retroactively, with available information, document a complete investigation report of the alleged incidents of caregiver misconduct described in Statement of Deficiency (SOD) YU9Z15. The investigation will conform to requirements and guidelines specified by Wis. Admin. Codes ch. DHS 13, ch. DHS 83 and The Wisconsin Caregiver Program Manual. - WITHIN 14 DAYS of receipt of this notice, the provider will submit a copy of the investigation report to the Department's Office of Caregiver Quality for department review."

Prior to conducting the onsite visit, Surveyor reviewed Department records. The retroactive investigations required by the orders were related to 3 different allegations of caregiver misconduct received by the provider in January 2024. Department records did not contain evidence the

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provider submitted a copy of the retroactive investigations to the Office of Caregiver Quality, as required by the special orders.

During the onsite visit, Surveyor reviewed a plan of correction (POC) binder for SOD YU9Z15, provided by Director A on 10/24/2024 at 8:10 AM. The documentation did not include evidence of the retroactive investigations from allegations received in January 2024, or review/revision of the Abuse/Misconduct policy that had been in effect since 2012.
The documentation did not contain evidence of a plan to correct all deficiencies in consultation with a RN. Surveyor noted there was a "Plan of Correction" document dated 06/07/2024 which assigned correction of certain deficiencies to certain managers (Director A, Regional Manager P, Administrator H and Dietary Staff JJ.) Of the 11 deficiencies, 4 were assigned to Administrator H who is a RN (Resident Rights to Receive Medications, Written Orders for Medications, Documentation of Medication Administration.)

Surveyor interviewed Regional Manager P (who is not a RN) on 10/22/2024 at 10:30 AM. S/he stated since the enforcement orders dated 06/07/2024, the provider had not revised policies and procedures. She commented, "Our policies and procedures are standard, company wide at all 29 facilities."

Surveyor interviewed Director A (who is not a RN) on 10/24/2024 at 11:08 AM. Director A stated Administrator H was only responsible for portions of the POC, as documented on the POC dated 06/07/2024. Director A said a consulting firm not associated with the facility was not hired until 10/07/2024, four months after the special orders. Finally, Director A said s/he did not complete and

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was not aware of anyone else completing the retroactive caregiver misconduct investigations as ordered.

Surveyor interviewed Administrator H, Regional Manager P and Licensee N on 10/30/2024 at 10:00 AM. Surveyor asked Administrator H what his/her role was in the development of the POC. Administrator H replied, "It would be input. That's why it was written down. I would have to re-review the documentation. What is in the binder would probably tell you what I contributed to it. I'm sure it had a lot to do with medication ..."

Surveyor asked about the enforcement orders for retroactive investigations and the requirement to correct all identified deficiencies in consultation with a RN. Regional Manager P confirmed the only other consulting activity was with the Consulting Agency KK, hired in the beginning of October. Neither Regional Manager P nor Administrator H recalled conducting any retroactive investigations and did not have an awareness of the order for the retroactive investigations.

During the interview, Surveyor showed the managers the aforementioned POC document dated 06/07/2024. Licensee N said, "What you are showing me now, is the first time I am seeing this." Licensee N said s/he thought the document may have been more of a resource for Director A than an actual POC. Surveyor asked Licensee N if s/he was aware of any other documented POC and s/he replied, "If there is any other POC ...I would not know that." Regional Manager P responded and said the document dated 06/07/2024 was in fact the POC developed in response to the previous SOD. S/he said, "As you can see it is very straightforward. Then anything

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else would be with [Consulting Agency KK.]"

TERMINATION OF CONTRACT RESULTING IN RESIDENT RELOCATION

On 10/30/2024 at 3:30 PM, MCO S emailed Surveyor a notice dated 09/10/2024 which read in part, "Dear [Licensee N]: [MCO S] is sending this notification to advise you that the subcontract agreement between [MCO S] and Care Partners Assisted Living- Stevens Point (building 2) will be terminated as of 10/10/2024. This termination is...a for cause for termination due to deficiencies in quality of service. [MCO S] will be working with you to move members out of the facilities within the next 30 days." At the time the notice was issued, 6 of 7 residents received services from MCO S.

As of 10/22/2024 when Surveyor conducted the onsite visit, all 6 residents has been relocated and the census was 1. On 10/22/2024, Director A provided Surveyor a copy of an involuntary discharge notice that was issued to the remaining resident on 10/15/2024. The notice was signed by Licensee N was not based on reasons permitted by the code.

PATTERN OF NONCOMPLIANCE

During the past 6 years, the provider displayed a pattern of ongoing noncompliance with regulations.

The current survey, SOD YU9Z16 ending on 11/06/2024, identified 11 new deficiencies resulting from 3 of 3 substantiated complaints. The 11 new deficiencies included the following recites:

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{N 196}	Continued From page 27 Caregiver: Investigating Abuse & Neglect - fourth recite and uncorrected from SOD YU9Z15 Investigate Injuries of Unknown Source - recite and uncorrected from SOD YU9Z15 Licensee Ensures Facility Complies with Laws - third recite and uncorrected from SOD YU9Z15 Administrator Shall Supervise Daily Operations - recite and uncorrected from SOD YU9Z15 Rights of Residents: Free from Mistreatment - third recite (last cited SOD YU9Z14) Rights of Residents: Receive Medications - third recite and uncorrected from SOD YU9Z15 Service Plans Updated Annually Or On Changes - third recite and uncorrected from SOD YU9Z15 Qualified Staff In Charge, On Duty And Awake - recite and uncorrected from SOD NCQ011 Leisure Time Activities - third recite and uncorrected from SOD YU9Z15 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 - The provider did not investigate to determine if caregivers responded in a neglectful manner and contributed to Resident 9's death after they discovered s/he was entrapped between the bed and bed rail. Orientation - A caregiver did not receive training in topics to include preventing and reporting abuse and neglect. Advanced Directives - Accurate documentation of advanced directives was not in the resident records and paramedics performed CPR on a resident against his/her wishes. Resident Rights: Free From Mistreatment - (1)	{N 196}		

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{N 196}	Continued From page 28 Two caregivers (including the aforementioned caregiver who did not receive abuse/neglect training) made Resident 9 (diagnosed with dementia) stay in bed during an episode when s/he was actively and unsafely trying to self-transfer. The resident physically resisted and verbally objected to the confinement. The resident was then left unsupervised in bed for up to an hour after it was known s/he was incontinent and had a blood sugar greater than 400 mg/dl. When a caregiver returned, Resident 9's head and neck were entrapped between the bed and the bed rail with his/her body on the floor. The resident died as a result of positional asphyxia. (2) A resident was not provided clean bed sheets or assistance to ensure s/he wore clean clothes and was not provided appropriate feeding assistance to meet his/her needs. The resident lost 11 pounds in 2 months. Resident Rights: Self-Determination - A caregiver routinely brought his/her dog to work and exposed a resident to the dog, in spite of the resident's known dislike for the animal. The resident had diagnoses to include dementia and was upset, agitated and hostile when the animal was present. Pre-Admission and Ongoing Assessments - the provider did not assess the ongoing risk of physical injury in association with the bed rail on Resident 9's bed and his/her known tendency to attempt to unsafely transfer out of the bed Service Plans Updated Annually Or On Changes - individual service plans for 3 residents were not updated based on assessment to identify fall risk/prevention, elopement risk, behavior management or the use of PRN psychotropic medications. Infection Control Program - The provider did not develop or revise an existing infection control policy from 2012 to ensure current standards of	{N 196}		

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{N 196}	Continued From page 29 practice were implemented for the prevention, identification and response to COVID-19 infection. 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 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 - 2 of 2 caregivers did not know a resident's DNR (do not resuscitate) status and were unable to locate documentation of advanced directives/DNR orders. Infection Control Program - the provider did not correct the previous deficiency identified in SOD YU9Z12. The provider did not review or revise their policy from 2012 and did not implement current standards of practice for the prevention, identification and response to COVID-19 infection.	{N 196}		

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{N 196}	Continued From page 30 Interior Floors, Walls and Ceilings Special order: "Pursuant to Wis. Stat. § 50.03(5g)(b)6., the licensee shall development (or review/revise) a written procedure and conduct staff training to address: Infection Control, including how the provider will implement an infection control program based on current standards of practice to prevent the development and transmission of communicable disease and infections. The infection control program will include, at a minimum, current guidance for the prevention, identification, and monitoring of respiratory infections, including COVID-19, along with Transmission-Based Precautions to be used when caring for residents." 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 - The licensee did not comply with Department orders to develop (or review/revise) and implement an infection control program based on current standards of practice for the prevention, identification and monitoring of COVID-19, and staff training. 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, 1 of 7 deficiencies uncorrected and 4 new deficiencies Caregiver: Investigating Abuse & Neglect - The provider had knowledge a caregiver was "a bully," was treating residents disrespectfully and received a written allegation of verbal/mental	{N 196}		

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{N 196}	Continued From page 31 abuse from a resident. The provider did not investigate the concerns. The same caregiver went on to mistreat a resident. Resident Rights: Free From Mistreatment - the aforementioned caregiver denied a resident food and drink, yelled and him/her and confined the resident to their room. 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. SOD YU9Z15, dated 04/30/2024 - 3 of 3 complaints were substantiated, 2 of 4 deficiencies were uncorrected and 11 new deficiencies Caregiver: Investigating Abuse & Neglect - the provider did not investigate allegations of abuse or neglect and/or take immediate steps to protect residents after allegations were reported 3 times during January 2024. Investigate Injuries of Unknown Source Licensee Ensures Facility Complies with Laws Administrator Shall Supervise Daily Operations Rights of Residents: Receive Medications - a resident received 8 times the dose of insulin that was prescribed and was treated in the emergency department for 7 hours due to insulin overdose. Upon discharge the physician ordered a 10 day increase in prescribed magnesium but it was not administered. Service Plans Updated Annually Or On Changes - 2 residents' individual service plans were not revised to accurately reflect physician ordered	{N 196}		

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texture modified diets or to identify their diagnoses of diabetes and associated dietary needs. Caregivers served food that presented a choking risk and did not offer options for low carbohydrate or low sugar meal options.
Written Orders for Medications, Supplements.
Documentation of Medication Administration - a caregiver inaccurately documented a resident was given the correct dose of a insulin when s/he was not and a different caregiver documented administration of a medication that was never given.
Other Administration Given or Delegated by RN
Leisure Time Activities
Care - a resident was heavily incontinent of urine during the overnight hours and the incontinence pad on the bed was damp with urine. A caregiver changed the resident's brief but returned the resident to bed without replacing the soiled incontinence pad. The provider did not communicate with the same resident's physician to ensure an order for a urinalysis was satisfied and subsequently did not notify the physician after the resident displayed signs and symptoms of a urinary tract infection.

In addition to the aforementioned summary of citations, during the surveys conducted between 2018-2024, the facility was not well maintained to provide a homelike environment. Odors were present and flooring and walls were not maintained for safety. Leisure time activities were not provided. Assessments were not completed.

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

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{N 196}	Continued From page 33 Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations N0327 DHS 83.31(4)(b) Allowable Reasons For Involuntary Discharge N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medications N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0397 DHS 83.36(1)(b) Qualified Staff in Charge, On Duty And Awake N0408 DHS 83.37(1)(i) PRN Psychotropic Medication N0427 DHS 83.38(1)(c) Leisure Time Activities	{N 196}		
{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 H did not supervise the daily operations of the CBRF to ensure residents received necessary care and services.	{N 214}		

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{N 214}	Continued From page 34 Administrator H did not ensure deficiencies from the previous survey were corrected and did not monitor medication systems to ensure residents received all medications in the doses and intervals prescribed. In addition, Administrator H did not ensure an investigation was immediately conducted after law enforcement made an allegation of caregiver neglect and did not ensure accurate information was reported to the Department regarding the incident. This is a repeat deficiency. See Statement of Deficiency YU9Z15, dated 04/30/2024. Findings include: DAILY OPERATIONS On 10/22/2024, Surveyor conducted the first of 3 consecutive facility visits. Director A was present all 3 days. S/he was joined on the first two days by Regional Manger P. On the third day no corporate management staff joined Director A. During 3 of 3 visits, Administrator H was not present onsite. During an interview with Regional Manager P on 10/23/2024, s/he said Administrator H was last onsite "a week ago or 2 weeks ago" and said Administrator H is usually in the facility 2 or 3 times a month. S/he also stated, "[Administrator H] had a scheduled visit here yesterday, then with you here, that got postponed." Surveyor asked why Surveyor's presence would postpone the visit and Regional Manager P said, "We thought it would be busy." On 10/24/2024, at 9:31 AM, Surveyor reviewed Director A's employee record. On his/her employment application for a secretarial position	{N 214}		

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{N 214}	Continued From page 35 dated 02/01/2021 s/he wrote, "Currently getting my GED." Director A's record did not contain evidence of completion of the administrator course, an associate or bachelor's degree or a nursing home administrator license. It did not contain evidence s/he was a registered nurse (RN.) On 10/24/2024, during an interview beginning at 11:08 AM, Director A became emotional and acknowledged feeling overwhelmed. S/he stated s/he has been responsible for the day to day operations of the facility and was doing the best s/he could. Surveyor asked if s/he had completed the administrator course or was an RN, and s/he said s/he was not. On 10/30/2024 at 10:00 AM, Surveyor interviewed Administrator H and s/he explained s/he is a regional nurse for "11 or 12 different sites, about 15 different buildings" within the organization. Surveyor conducted interviews which indicated Administrator H was not routinely present at the facility overseeing operations. Interviews also identified concerns with Director A. Examples include: Interview with Assistant Director K on 10/22/2024 at 12:09 PM - S/he said Administrator H did a "walk though" about a week ago, but before that s/he had not been onsite regularly. Assistant Director K also said, "I've called [Administrator H] a few times. Then [s/he] calls Director A and Director A sends texts and says, 'You don't need to contact corporate.'" Interview with POA FF (Resident 8's power of attorney) on 10/22/2024 at 9:23 AM - S/he expressed frustration about Director A's oversight	{N 214}		

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and said s/he did not know who Administrator H was. POA FF said s/he in the building often visiting Resident 8.

Interview with POA LL (Resident 7 POA) on 10/28/2024 at 2:07 PM - S/he said s/he did not know Administrator H and s/he could not recall Director A's name. S/he said the former Director was in frequent contact but "When this other person whoever they are took over, I never heard a thing from [him/her]."

Surveyor reviewed the provider's plan of correction (POC) documentation for SOD YU9Z15, provided by Director A on 10/24/2024. It read in part, "Administrator Shall Supervise Daily Operations" and documented 3 assignments for Director A related to Resident 1's ISP and Resident 1 & 6's dietary orders. No other corrective steps were identified for this deficiency.

As a result of the verification visit and complaint investigations, 11 deficiencies were identified which included 8 uncorrected deficiencies from the previous 2 surveys.

MEDICATION CONCERNS
Prior to the onsite visit, Surveyor reviewed the deficiencies from the SOD YU9Z15, dated 04/30/2024. Two deficiencies were identified related to Resident 1's medications, including concerns with the administration and documentation of estradiol cream.

Surveyor reviewed medication orders and medication administration records (MARs) from Resident 1's record on 10/23/2024 at 1:19 PM to verify correction of the deficiencies:
04/02/2024 order for estradiol cream: "pea sized amt to urethra nightly x 2 weeks then every

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 214}	Continued From page 37 M/W/F" and myrbetriq 50 mg pill once daily. AUGUST MAR: estradiol cream scheduled 8:00 PM with instructions, "Use pea sized amount nightly to the urethral area for 2 weeks, then use 2 to 3 times weekly thereafter." The MAR documented nightly administration of the medication for 18 consecutive days from 08/01-08/18/2024. AUGUST MAR: myrbetriq 50 mg tablet with instructions for daily administration. It was not documented as not administered 08/01 and 08/02. No reason was documented. AUGUST MAR: rosuvastatin calcium 40 mg tablet with instructions for daily administration. It was not documented as administered 08/01 - 08/05. No reason was documented. "0/01/2024 order for levothyroxine sodium changed from 88 mcg to 75 mcg daily. OCTOBER MAR: levothyroxine 88 mcg tablet documented as administered daily 10/01-10/15/2024 (Resident 1's move out date.) Surveyor interviewed Director A on 10/23/2024 at 2:15 PM and s/he confirmed Surveyor's review of the orders and MARs. Director A said s/he was not previously aware of the concerns. Surveyor asked who has responsibility to audit the medication administration systems. Director A said s/he audits MARs but the assistant director is supposed to "run through" the medication carts and "check daily" because they are regularly administering medications. While reviewing the aforementioned POC documentation, Surveyor noted the following: "Documentation of Medication Administration - [Administrator H]: all around med admin retraining and importance of meds being locked up." "Rights of Residents to Receive Medications -	{N 214}		

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{N 214}	Continued From page 38 [Administrator H]: med cart audits twice a month..." "Medication Administration QA Audit" forms completed 08/12/2024 by Assistant Director G, 08/19 by Director A, 08/20 by Administrator H and 08/28 by Assistant Director G. Surveyor noted none of the 3 audits identified concerns with estradiol cream or medications not administered without a documented reason. Surveyor interviewed Administrator H on 10/30/2024 at 10:00 AM. Surveyor showed Administrator H the August 2024 MAR along with the 3 audit forms completed in August 2024. Administrator H did not have additional information to provide about why concerns on the MAR were not identified during audits, including during the audit s/he completed on 08/20/2024. Surveyor asked Administrator H if s/he had information about why the October 2024 MAR continued to prompt for and document administration of 88 mcg levothyroxine contrary to the 10/01/2024 order for a 75 mcg dose. Administrator H replied, "I would have to be in the building to review the MAR." MISCONDUCT INVESTIGATION AND INCIDENT REPORTING On 10/25/2024 at 1:38 PM, Administrator H authored and submitted a Misconduct Incident Report to the Department's Office of Caregiver Quality regarding a caregiver misconduct incident on 10/19/2024. It read in part, "Director notified by local law enforcement that a staff member had called EMS related to being intoxicated at work ...One resident was soiled, the other resident was at baseline. Due to memory issues, neither is an accurate historian. Both interviewed ...Director began investigation immediately by getting statements from staff and followed up with	{N 214}		

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{N 214}	Continued From page 39 resident interviews and contact with the visiting officers." Surveyor interviewed Director A on 10/22/2024 at 10:25 AM and Regional Manager P joined at approximately 10:30 AM. During the interview, Director A provided documentation of his/her investigation which s/he said was complete other than the need to obtain a statement from one of the involved caregivers. On 10/23/2024, Regional Manager P provided additional documentation of the investigation. Based on the interview and record review Surveyor noted the following: Director A received the allegations from law enforcement beginning on 10/19/2024 at 10:29 PM. Based on direction from Administrator H, s/he did not begin his/her investigation until the morning of 10/21/2024. Both residents were not interviewed. Director A did not follow up with the officers who responded onsite until s/he requested the police report on 10/23/2024, one day after Surveyor arrived onsite to review the incident. Surveyor interviewed Resident 8 on 10/22/2024 at approximately 9:30 AM. Surveyor observed Resident 8 had some limitations with communication due to his/her diagnoses, however s/he was able to provide relevant details about his/her care on 10/19/2024, and other topics. During the interview, Resident 8's power of attorney for health care was present. S/he confirmed Resident 8 was able to be interviewed, it was just important to talk slow and give him/her time to respond. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0161 DHS 83.12(3) Investigate Injuries of	{N 214}		

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{N 214}	Continued From page 40 Unknown Source N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0327 DHS 83.31(4)(b) Allowable Reasons For Involuntary Discharge N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medications N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0397 DHS 83.36(1)(b) Qualified Staff in Charge, On Duty And Awake N0408 DHS 83.37(1)(i) PRN Psychotropic Medication N0427 DHS 83.38(1)(c) Leisure Time Activities	{N 214}		
N 327	83.31(4)(b) Allowable reasons for involuntary discharge. Discharge or transfer initiated by CBRF. Reasons for involuntary discharge. The CBRF may not involuntarily discharge a resident except for any of the following reasons: 1. Nonpayment of charges, following reasonable opportunity to pay. 2. Care is required that is beyond the CBRF ' s license classification. 3. Care is required that is inconsistent with the CBRF ' s program statement and beyond that which the CBRF is required to provide under the terms of the admission agreement and this chapter. 4. Medical care is required that the CBRF cannot provide. 5. There is imminent risk of serious harm to the health or safety of the resident, other residents or employees, as documented in the resident ' s record. 6. As provided under s. 50.03 (5m), Stats. 7. As otherwise permitted by law.	N 327		

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N 327	Continued From page 41	N 327		

This Rule is not met as evidenced by:
Based on record review and interview, on 10/14/2024 the provider initiated the discharge of Resident 4 for reasons inconsistent with the reasons permitted by the code.

Findings include:

Surveyor interviewed Director A on 10/22/2024 at 10:45 AM. S/he explained in the past week all residents but 1 had moved out and the remaining resident, Resident 8 had been issued a discharge notice. Director A said s/he was not involved in the decision to discharge but according to letter provided by the corporate office, the reason for discharge was "restructuring." Regional Manager P subsequently joined the interview and stated the discharge notice was "due to staffing levels and going forward with restructuring and we are unable to provide cares...We are looking at major renovations and things and [Licensee N] is deciding next steps for the 2 facilities...The thirty-day notices were given at [Licensee N]'s directive."

Director A provided Surveyor a copy of Resident 8's notice during the interview. It was dated 10/15/2024, addressed only to MCO Representative O and read in part, "We regret to inform you that at this time (we)...must issue a thirty-day notice to [Resident 8]. Care Partners Stevens Point will be undergoing restructuring and we feel we have no choice but to issue this thirty-day notice. [Resident 8] ' s last day of residency...will be November 13, 2024. By this date, please have all [Resident 8]s belongings removed from the facility. We will do everything

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we can to help with locating a new residency [sic]..." The letter was signed by Licensee N.

Surveyor interviewed Assistant Director K on 10/22/2024 at 10:00 AM. S/he volunteered concerns about the involuntary discharge notice issued to Resident 8. S/he said, "It bothers me they gave a 30 day. No reason was given, just to reconstructure." [sic]

On 10/25/2024 at 10:10 AM, Director A emailed Surveyor and wrote, "Hello, These are the 30 day notices that were issued reissued [sic] to the families, was giving these to you to make sure that you had these for you file. Thank you." Attached to the email was a different version of the notice. It was dated 10/17/2024 and still only addressed to MCO O. The reason for discharge had changed. The notice read in part, "Due to the staffing shortages we are experiencing we feel we cannot adequately meet the medical needs of this resident. We feel we have no choice but to issue this thirty-day notice. Care Partners does have other facilities that are fully staffed that would be able to transfer [Resident 8] if you would choose to. [Resident 8]'s last day of residency...will be November 15, 2024. By this date, please have all [Resident 8]'s belongings removed from the facility..." The letter was signed by Licensee N.

On 10/30/2024 at 10:00 AM, Surveyor conducted an interview with Licensee N and Regional Manager P. Licensee N confirmed the discharge notices were issued and stated, "We have staff that are leaving the operation because they are down to...1 resident and we don't know what the future of the building holds with the no new admission order, so long-term I don't know we would be able to meet the needs of the

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N 327	Continued From page 43 residents." (Surveyor note: the provider is currently under special orders from the Department not to admit new residents due to the survey findings in YU9Z15, 04/30/2024.) During the interview, Surveyor informed Licensee N and Regional Manager P the reasons for discharge were not consistent with the reasons permitted in DHS 83.31. Regional Manager P responded, "One of the reasons to give notice is failure to meet residents needs and we are stating that we are failing to meet (the resident's) needs." Surveyor again reviewed the permitted reasons for discharge, along with the requirement of DHS 83.36(1)(a) to provide sufficient staff to meet the needs of the residents. Neither Licensee N nor Regional Manager P provided additional information as evidence the involuntary discharge notice was issued based on one of the permitted reasons in DHS 83.31. 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 327		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property.	N 348		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 8 was free from neglect. On 10/19/2024, Caregiver Y worked from 2:00 PM - 9:45 PM. During his/her shift, Resident 8 was sick and experienced episodes of diarrhea. Caregiver Y last provided incontinence care to Resident 8 between 6:00 - 6:30 PM. Caregiver Z arrived at the facility between 8:00 - 8:30 PM. Caregiver Z was intoxicated and brought Caregiver Y's 2 young children. Caregiver Y had to provide care to his/her own children and did not check on or provide incontinence care to Resident 8 prior to the end of his/her shift. Police responded after Caregiver Z made 911 calls beginning at 9:44 PM and reported s/he was drunk and having problems caring for a resident. Police administered a preliminary breath test and Caregiver Z registered 0.248, more than 3 times the legal limit for driving. At approximately 11:00 PM, a relief caregiver and police officer checked Resident 8 and found him/her "covered" in wet and dry feces. Caregiver Z was arrested for neglect of a resident and after further investigation, Caregiver Y was referred to the District Attorney for possible neglect charges.

This is a repeat deficiency being cited for the third time. See Statement of Deficiency (SOD) YU9Z11, dated 02/25/2021 and SOD YU9Z14, dated 08/16/2023.

Findings include:

The Department received a complaint alleging resident neglect.

Surveyor reviewed Resident 8's facility file on

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N 348	Continued From page 45 10/22/2024. Resident 8 had diagnoses to include major depressive disorder, dementia and anoxic brain injury. Resident 8's individual service plan dated 07/02/2024 noted s/he ambulated with a walker, needed staff assistance with activities of daily living, was on a 2 hour schedule for incontinence checks. and needed to "be in eyesight of staff at all times to make sure that [s/he] is free from falls due to trying to self transferring [sic]." Surveyor reviewed Stevens Point Police Department report C24-11464 on 10/22/2024 and noted the following: On 10/19/2024 at approximately 9:48 PM, Officer DD was dispatched to the facility after a 911 call and a series of hang ups with Caregiver Z. According to his/her report: --Caregiver Z called 911 at 9:44 PM and hung up. The dispatcher called Caregiver Z back and s/he hung up again. Dispatch called again and could "hear someone in the background yelling. [Caregiver Z] explained that [s/he] was in the room with a dementia patient who had gotten stuck in their chair after falling...dispatch believed [Caregiver Z] sounded panicked and was quick to hang-up the phone." Upon arrival, Officer DD was met by Caregiver Y in the parking lot and s/he was "extremely distraught and in tears." Caregiver Y said Caregiver Z drove drunk to the facility about an hour ago with Caregiver Y's kids in the vehicle. Caregiver Y explained Caregiver Z was "slurring [his/her] speech" and had "trouble with coordination." The children were present and were ages 11 and 4 years old. Caregiver Y said s/he and the 11 year old tried to take away a bottle of alcohol from Caregiver Z while the 3 were in the facility bathroom. While Officer DD was talking with Caregiver Y, Caregiver Z called	N 348		

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N 348	Continued From page 46 911 again and stated s/he was inside the facility, was "drunk" and needed to be taken home. Officer DD entered the building and met with Caregiver Z who said s/he had been drinking, had possession of facility keys and was trying to give out the last of the bedtime medications. Caregiver Y stated s/he had already administered the medications. At 10:41 PM, Officer DD conducted a preliminary breath test and Caregiver Z registered 0.248, more than 3 times the legal limit for driving. On at 10:29 PM, Sergeant (Sgt) EE arrived to assist Officer DD. According to his/her report: --Sgt EE contacted Director A, informed him/her Caregiver Z was too intoxicated to care for residents and requested relief staff. Caregiver J arrived (approximately 11:00 PM) and was joined by Sgt. EE to walk through the facility. Sgt. EE and Caregiver J observed the kitchen was in disarray with a sink was full of dishes with more dirty dishes scattered on the counter. Sgt. EE went to retrieve a camera and when s/he returned, Caregiver J stated Resident 8 was "covered in feces." Sgt. EE observed Resident 8 and wrote, [Resident 8] was "laying on [his/her] left side, but awake, looking at me...[Caregiver J] lifted a blanket from [Resident 8] in which [sic] I observed feces covering [Resident 8]'s legs, waste [sic] area, and buttocks as well as all over the bed as if [s/he] was laying in it for some time. [Resident 8] was also naked from the waste [sic] down. I took a photograph and exited the room." Caregiver J told Sgt. EE the other resident was OK, and Caregiver J was left to assume care of both residents. Surveyor interviewed Caregiver Y on 10/22/2024 at 2:26 PM. S/he explained on 10/19/2024, s/he was scheduled alone 2:00 PM - 10:00 PM in this	N 348		

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facility (building 2). Caregiver Z, who is his/her boy/girlfriend, arrived between 8:00 PM - 8:30 PM to work in the sister facility (building 1). S/he explained Caregiver Z was supposed to be there by 6:00 PM but was late. Caregiver Z also brought Caregiver Y's children, which is their routine when one relieves the other at work. Caregiver Y did not say what the plan was for the children if each caregiver had worked in their own building as scheduled. Caregiver Y said ultimately, Caregiver Z stayed in building 2 and clocked in at 8:45 PM while Caregiver Y was still on duty. Caregiver Y said eventually it became clear Caregiver Z was drunk, it was upsetting and it consumed Caregiver Y's time and attention. S/he said there was "a lot going on at the time," the kids were "acting up" and s/he was "trying to keep them in the car. My 4 year old doesn't like to listen at all." Caregiver Y said s/he explained to Caregiver Z that Resident 8 "would need to be checked on soon" because s/he was sick, but s/he did not know if Caregiver Z provided care to Resident 8. Caregiver Y said s/he was very upset with Caregiver Z but also upset with him/herself. S/he recalled, "[Resident 8] was toileted, checked and changed after dinner between 6 and 6:30 PM" but s/he did not check for incontinence after that even though Resident 8 had multiple episodes of diarrhea during the day. Caregiver Y said, "I knew [s/he] wasn't feeling well ...I didn't check [him/her] again before I left. That's my fault." (Surveyor note: Caregiver Y initially said Resident 8 had 4-5 episodes of loose stools between 2:00 PM and 6:30 PM, but then changed his/her statement to say there were only 2 episodes in that timeframe.)

Surveyor interviewed Caregiver J on 10/23/2024 at 2:36 PM. Caregiver J recalled responding to the facility on 10/19/2024 and said, "The police

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met me in the parking lot...[Caregiver Y] and [his/her] kids were sitting in the car. I could hear the kid screaming, the younger one." Caregiver J said when s/he checked on Resident 8 and pulled back the covers, "I got BM (bowel movement) on my hand. It was all over the bed, on the chucks (incontinence pad), on [Resident 8]. Part of it was wet, part of it was dry. [S/he] was really agitated. [S/he] was yelling at me." Caregiver J said Resident 8 was not wearing a brief or undergarments which was not typical and Caregiver J did not locate a soiled brief anywhere in the room. Caregiver J said it was difficult to clean Resident 8 and s/he was agitated and yelling. Caregiver J said, "I went through a pack of wipes. [S/he] wasn't happy. I had to push hard to get the dry stuff off."

Surveyor interviewed Resident 8 on 10/22/2024 at approximately 9:30 AM. Surveyor asked Resident 8 if s/he could tell Surveyor what happened on Saturday night. Resident 8 replied, "[S/he] was supposed to take care of me. [S/he] came in my room and [s/he] changed my diaper. And then [s/he] left me. And I laid there for over an hour." Surveyor noted Resident 8 used the gender that matched Caregiver Z. Resident 8 confirmed s/he wasn't feeling well. Surveyor asked if s/he recalled anything else and s/he replied, "[S/he] didn't change my bedding...Still had diarrhea on my sheets...on my [bottom]. [S/he] said [s/he] would come back." Resident 8 also volunteered, "[Caregiver Y]'s kids. They were here...It was noisy. Chaotic. They were running around." Resident 8 also said "eating dinner" was chaotic because the "kids were just annoying, running around." Resident 8's power of attorney (POA FF) was present during the interview and expressed overall concerns about the facility. Surveyor asked if s/he complained to Director A

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 348	Continued From page 49 and s/he said no. Resident 8 interjected, "I complained. About how [s/he - Caregiver Z] left me in a [expletive for BM] mess." POA FF stated, "I will get [Resident 8] out of here as soon as I find another place." Surveyor note: Resident 8's statement that Caregiver Y's children were there during dinner, the officer's observation of the kitchen in disarray and Caregiver Y's statement that Caregiver Z was supposed to be at work at 6:00 PM, indicates it is possible Caregiver Z was in the building before 8:00 PM. Surveyor reviewed a supplemental report for C24-11464 authored by Detective R on 11/06/2024. The report noted Detective R was making a referral to the District Attorney to review for neglect charges for Caregiver Y along with Caregiver Z, since they were both working at the time of the incident. 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 348		
{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	{N 352}		

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{N 352}	Continued From page 50 is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 8 received all medications as ordered. On 09/24/2024, Resident 8's medications for October were delivered to the facility. Prescribed mirtazapine was not included in the delivery and the provider was informed a new refill order was necessary. The provider did not make efforts to obtain the new order prior to 10/01/2024. Resident 1 went without the medication from 10/01 - 10/06/2024. On 10/06/2024, the medication for the remainder of October was delivered beginning with the 10/07/2024 dose. Caregivers did not resume administration of the medication until 10/08/2024. This is a repeat deficiency being cited for the third time. See Statement of Deficiency (SOD) YU9Z12, dated 09/01/2022 and SOD YU9Z15, dated 04/30/2024. Findings include: Surveyor interviewed Resident 8's power of attorney (POA FF) on 10/22/204 at 9:23 AM. POA FF said s/he's had problems with some of Resident 8's prescriptions and a lack of responsiveness from Director A when s/he tries to resolve. POA FF commented, "I felt like [Director A] should handle it," instead of relying on caregivers. On 10/23/2024 at 8:01 AM, Assistant Director K showed Surveyor the medication administration system and records to verify compliance with the deficiencies identified in SOD YU9Z15. Surveyors observed the medications in the cart	{N 352}		

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{N 352}	Continued From page 51	{N 352}		

for Resident 8 which included a card of blister packaged medication for 15 mg of mirtazapine (used to treat depression and anxiety) scheduled daily for 8:00 PM. The blisters were numbered to align with the day of the month and the first date that was filled was 10/07/2024. The pill for that date remained in the blister. The pills in the blisters for the 8th - 22nd had been removed.

Surveyor and Assistant Director K reviewed Resident 8's October 2024 medication administration record (MAR.) Each night 10/01 - 10/07, caregiver initials (Caregivers J, Y and Z) were documented with a circle around them. Beginning 10/08, administration of the medication resumed. Assistant Director K confirmed when a caregiver circles their initials, it means the medication was not given and the reason should be documented on the back of the page. Assistant Director K showed Surveyor the back page. On 10/02 at 7:00 PM Caregiver Z wrote, "not in stock," on 10/04 at 7:00 PM Caregiver J wrote, "Phar called. Need new order," on 10/07 at 8:00 PM Caregiver J wrote, "Await. new order." [sic - all]

Assistant Director K did not have information as why the medication was not available 10/01 - 10/06, or why the pill in the 10/07 blister was not administered on that date.

Surveyor interviewed Director A and Regional Manager P (in Director A's office in building 1) at approximately 9:20 AM. Director A said Resident 8's power of attorney (POA FF - legal representative) complained about a "medication issue" the previous day, " something with a med issue that I had no idea about." Director A told POA FF, "I don't know what you are talking about, I will look with staff next door." Director A

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{N 352}	Continued From page 52	{N 352}		

said s/he talked with Assistant Director K about the situation and determined the concern was regarding a multivitamin order, but s/he did not go next door to building 2 to review the MAR as part of any efforts to resolve.

Director A and Regional Manager P then reviewed the MAR and the mirtazapine medication card with Surveyor. They confirmed Surveyor's aforementioned observations. Both confirmed this was a medication that had been prescribed for months but neither had information about why the medication was not administered for the first 6 days of the October. Assistant Director K was also present and discussed problems with the multivitamin order but did not describe any efforts to resolve the mirtazapine order.

At 10:13 AM, Director A said s/he called the pharmacy and learned the medication was not filled with the monthly cycle refill because the doctor needed to write an updated prescription. The pharmacy stated the order was not updated until 10/06 and delivered that evening with the medication being available for administration beginning on the 7th. Director A could not provide information about the provider's efforts to resolve the medication concern prior to or after 10/01, and said s/he would need to collect more information.

At 10:23 AM, Director A provided Surveyor with the following documentation:
Director A handwritten note, "Prescription was written on the 6th, it was filled on the 6th, sent out that night. Nothing was changed, doctor had to write a new order."
10/03/2024 - facility reorder form addressed to the pharmacy for the medication, signed by

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{N 352}	Continued From page 53	{N 352}		

Assistant Director K with a handwritten note, "faxed 10/3...9:00 am" The form did not include a fax confirmation.
10/05/2024 - facility reorder form addressed to the pharmacy for the medication, signed by Assistant Director K with a handwritten note, "faxed 10/5...8:00 am" The form did not include a fax confirmation.
10/07/2024 - facility reorder form addressed to the pharmacy for the medication, signed by Caregiver J with a handwritten note, "faxed 10/7." This form did have indications of a fax header, but it was illegible.

Director A informed Surveyor s/he did not have any information about efforts to refill the prescription prior to 10/01/2024.

At approximately 1:00 PM, Surveyor conducted a follow up interview with Assistant Director K and asked if s/he had knowledge of efforts to ensure the medication was refilled prior to 10/01, or as soon as it was discovered the medication was not available. Assistant Director K said Caregiver J contacted the pharmacy but said s/he was unsure if there was any documentation of it. Assistant Director K did not state that s/he sent faxes to the pharmacy.

Upon request on 10/24/2024 at 10:53 AM and 4:32 PM, Pharmacist GG emailed Surveyor the following:
Copy of an order from June 2024 used to refill the medication through the end of September.
Delivery manifest for the October medication cycle. Medications were delivered 09/24/2024 at 7:47 PM, signed for by Caregiver Y. According to the manifest, mirtazapine was not delivered. The medication was highlighted with a note, "need new rx." In addition, a document was left with the

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{N 352}	Continued From page 54 provider which read, "Rx (prescription) Help Needed...In preparation for the upcoming cycle exchange, the following prescription (mirtazapine) has not been filled. Reason: No Refills." The communication noted the pharmacy had not been successful with efforts to contact the prescriber and read, "please contact the prescriber and verify if the medication is to be continued...If yes, please ask that orders are sent." Pharmacist GG wrote they were "unable to locate" copies of faxes received from Care Partners on 10/03, 10/05 or 10/07. Surveyor reviewed portions of Resident 8's record on 10/22 and 10/23/2024. It included a physician's order for mirtazapine, signed on 06/20/2024, authorizing 90 tablets with zero refills. Resident 8's individual service plan (ISP) indicated medications were administered by facility staff. A behavior monitoring log from August 2024 documented diagnoses of anxiety and depression, targeted behaviors of "Sad, Crying, Isolation...Panic, Parinoid [sic]." No behaviors were charted during the month. October 2024 observations notes (through 10/21) included 34 different entries. Only one behavior was documented on 10/07/2024, six days after not receiving prescribed mirtazapine: 10/07: "Resident was unplesent [sic] whole shift. Resident aggressive [illegible] writer. Resident yelled at another resident, Resident tried to hit writer when changing resident, threw food on floor in anger. [Assistant Director] notified of behaviors." Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall	{N 352}		

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{N 352}	Continued From page 55 Supervise Daily Operations	{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 interview and record review, the provider did not ensure Resident 6, Resident 1 and Resident 7's individual service plans (ISPs) were updated to identify needs and corresponding interventions. Resident 6 did not have any teeth or dentures, had a diagnosis of dysphagia and had a physician's order for a mechanical soft diet. Resident 6's ISP was not updated to identify his/her diagnoses of dysphagia or the risks it presented. The ISP did not accurately or clearly reflect Resident 6's needs for a texture modified diet to ensure all food was soft and moist, required minimal chewing and did not require biting. Two of 2 staff interviewed described serving food that was not consistent with	{N 389}		

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{N 389}	Continued From page 56	{N 389}		

Resident 6's dietary needs and placed him/her at risk for choking.

Resident 1 had a history of urinary tract infections (UTIs). After visit summaries documented specific interventions for prevention, monitoring and early interventions if symptoms were present. Resident 1's ISP was not updated to identify the history or interventions. In early September 2024, caregivers documented at least 3 instances of blood in Resident 1's incontinence brief. Resident 1 was not medically assessed until 09/28/2024 and s/he was diagnosed with a UTI.

Resident 7 had experienced at least 5 falls over the course of 2.5 months. Resident 7's ISP was not updated to identify the history, risk or strategies for fall prevention.

Resident 6, Resident 1 and Resident 7's ISPs were not signed by the resident or the resident's legal representative, acknowledging their involvement in, understanding of and agreement with the plan.

This is a repeat deficiency being cited for the third time. See Statement of Deficiency (SOD) YU9Z11, dated 02/25/2021 and SOD YU9Z15, dated 04/30/2024.

Findings include:

The Department received a complaint alleging concerns related to fall prevention.

Prior to the onsite visit, Surveyor reviewed the deficiencies from Statement of Deficiency YU9Z15, dated 04/30/2024. A deficiency was identified due to Resident 6's ISP not being updated to reflect his/her diagnoses of dysphagia

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{N 389}	Continued From page 57 and physician orders for a texture modified diet and due to Resident 1's ISP not being updated to reflect his/her risks for UTIs. Surveyor reviewed the provider's Plan of Correction (POC) for SOD YU9Z15, provided by Director A on 10/24/2024 at 8:10 AM. The POC instructed, "Ensure [Resident 1]'s ISP is 100% perfect...[Resident 6]'s food/diet orders are retraining [sic]...Retraining staff on diets..." RESIDENT 6 Surveyor reviewed portions of Resident 6's facility record to confirm correction of the previous deficiency. Upon request on 10/24/2024 at 8:24 AM, Director A provided Surveyor with Resident 6's face sheet, most recent ISP and most recent physician's orders related to dietary needs. Resident 6 resided at the facility from 06/12/2023 until 09/11/2024. Director A provided a physician's order with an illegible signature and date which documented an order for a mechanical soft diet. Surveyor noted during the previous survey ending 04/30/2024, former Administrator T provided the same order, but subsequently obtained an updated order from the physician on 04/30/2024 that read, "Patient to be on mechanical soft diet." Dysphagia is a medical term for difficulty swallowing. Dysphagia can be a painful condition. In some cases, swallowing is impossible...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:	{N 389}		

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{N 389}	Continued From page 58 https://www.mayoclinic.org/diseases-conditions/dysphagia/symptoms-causes/syc-20372028, retrieval date 05/01/2024 Surveyor note: mechanical soft diet correlates with the "Minced and Moist" diet identified by the International Dysphagia Standardization Initiative (IDDSI.) Mined and Moist texture level foods are soft and moist, require minimal chewing and do not require biting. Examples include: "Meat served finely minced or chopped to 4mm lump size served in a thick, smooth, non-pouring sauce or gravy... Vegetables cooked, finely mashed or use a blender to finely chop it into to 4mm lump size pieces... NO REGULAR DRY BREAD due to high choking risk!..." Source: https://cms.iddsi.org/media/publications-iddsi/patienthandouts/english/adults/5_minced_moist_adults_consumer_handout_30jan2019.pdf, retrieval date 11/18/2024 Director A provided the current ISP dated 07/02/2024 which read in part, "Has no real teeth and does not have dentures...is on mech. Soft diet [sic] with meats cut up into smaller pieces for more ease...does cough at times while eating." The ISP: Did not identify Resident 6's diagnoses of dysphagia or indicate coughing could be a sign of swallowing difficulties associated with the diagnoses. Did not identify the need to modify any food other than meats. Did not accurately describe the modification necessary for meats. Did not include signatures from Resident 6 and/or	{N 389}		

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{N 389}	Continued From page 59 his/her legal representative to acknowledge their involvement in, understanding of and agreement with the individual service plan. Surveyor interviewed Director A on 10/24/2024 at 11:08 AM. Director A confirmed Surveyor's review of the records. Director A said staff were provided training as part of the POC but s/he did not have record of the training in employee files. Director A said s/he would send Surveyor evidence of the training. On 10/29/2024 at 7:55 AM, Director A emailed Surveyor documentation to show training occurred on 08/16/2024 on the topic of "Hormel Health IDDSI," provided by Regional Business Manager HH with Hormel Health Labs. No further outline of the course content was provided and the signature list of those who attended the training did not include Assistant Director K or Caregiver Y. Surveyor interviewed Assistant Administrator K (hire date 05/28/2024) on 10/22/2024 at 12:09 PM. S/he said the only modification s/he made to Resident 6's food was to cut his/her meat. S/he explained, "I noticed any dry meat like pork chops or meatloaf [s/he] had a problem with and would...spit it out." Assistant Director K also stated s/he felt like caregivers were "uneducated on what a mechanical soft diet is." Surveyor interviewed Caregiver Y (hire date 08/11/2024) on 10/22/2024 at 3:46 PM and discussed Resident 6's dietary needs. Caregiver Y said Resident 6 did not need a mechanical soft diet, s/he only needed some foods cut up because s/he "couldn't eat big or hard things because [s/he] didn't have teeth." Caregiver Y said resident was able to eat whole sandwiches if they were soft.	{N 389}		

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{N 389}	Continued From page 60 Surveyor interviewed Director A on 10/24/2024 at 11:08 AM about Resident 6's record. S/he confirmed Surveyor's review of the record and did not offer additional information. RESIDENT 1 Surveyor reviewed portions of Resident 1's facility record to confirm correction of the previous deficiency. Records included physician orders, after visit summaries, face sheet, ISP and observation notes. Resident 1 resided at the facility from 01/09/2024 - 10/16/2024 and had an activated power of attorney (POA) for healthcare. His/her diagnoses included dementia, schizophrenia and bipolar disorder. Resident 1 ambulated with the use of a walker and was on a 2 hour schedule for toileting and incontinence care. After visit summaries for medical appointments with Nurse Practitioner K on 03/12/2024 and Physician's Assistant N on 04/02/2024 identified Resident 1's risk of UTIs, diagnosis of urge incontinence and overactive bladder (OAB) and identified 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 (painful urination) intermittently. Sees Urology in April." 04/02: Presents today for consultation regarding frequent UTI ...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. It does seem like symptoms improve/resolve after antibiotic treatment...Nonspecific mild diffuse urinary	{N 389}		

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{N 389}	Continued From page 61 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 ...include bladder irritant avoidance, timed voiding, bladder training, pelvic floor exercises ..." Surveyor note: "A urinary tract infection (UTI) is an infection of 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	{N 389}		

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{N 389}	Continued From page 62 source: https://my.clevelandclinic.org/health/diseases/25008-urosepsis, retrieval date 05/01/2024 September 2024 observation notes: 09/01 NOC (third shift)- "Resident had blood in diaper coming from [genitals]. Resident was very confused due to blood." Author: Caregiver E 09/04 day shift - "Followed up with Dr. & notes. exspecially at night resident needs to be toileted, no soiled pads & was at Dr. oncology April, keep documenting. Today only a small brown spot seen by staff. no blood." [sic - all] Author: Assistant Director K 09/04 NOC- "Resident had small amount of blood on pad..." Author: Caregiver E 09/05 NOC - "Resident is still bleeding." Author: Caregiver E 09/28 day shift - "While toileting resident stated that it burned very bad when urinating. Resident stated that this just started happening. Writer noticed blood (small amount) in brief...Writer called non-emergency ambulance to have resident transported to hospital for evaluation. Resident diagnosed with a UTI ...prescribed an antibiotic." Author: Caregiver J 09/28/2024 after visit summary from emergency department: "Reason for Visit: UTI - Diagnoses: Urinary Tract infection...Start taking cephalexin" Resident 1's most current ISP was dated 07/02/2024. It was silent to the history of OAB or UTIs. It did not include instructions for monitoring or intervention as documented in the 04/02/2024 medical visit summary. The ISP was only signed by Director A with a post it note, "emailed to care team." The ISP was not signed by Resident 1 or his/her power of attorney, acknowledging their	{N 389}		

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{N 389}	Continued From page 63 involvement in, understanding of and agreement with the individual service plan. Surveyor interviewed Caregiver II on 10/23/2024 at 5:15 PM. S/he volunteered concerns about Resident 1 and said, "[Resident 1] had an episode when [s/he] was bleeding from [his/her] private area...we kept writing in the comment book and nothing got done...I'd say at least 2 weeks it would go away and then it would randomly come back and [s/he] would freak out and we would try to get [him/her] to calm down." Caregiver II expressed frustration that some staff attributed the bleeding to a condition that would be impossible for Resident 1 given his/her age. Surveyor interviewed Assistant Director K on 10/22/2024 at 12:09 PM. Assistant Director K confirmed Resident 1 was prone to UTIs with the most recent one being diagnosed in September 2024. Assistant Director K said prior to diagnoses Resident 1 had symptoms of blood in his/her urine for "a couple" of days, but s/he didn't necessarily attribute the symptoms to a UTI stating it could have been due to other reasons. Surveyor interviewed Director A on 10/23/2024 at 2:15 PM about Resident 1's records. S/he confirmed Surveyor's review of the records. Director A agreed the observation notes documenting blood in Resident 1's brief should have been viewed as possible signs of a UTI warranting medical assessment prior to 09/28/2024. Director A acknowledged s/he authored the ISP and it was silent to the history of UTIs and did not include interventions for monitoring or early interventions. Director A acknowledged the ISP was unsigned and did not offer email documentation to show potential efforts for Resident 1's POA to sign the ISP to	{N 389}		

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{N 389}	Continued From page 64 serve as acknowledgement of their involvement in, understanding of and agreement with the individual service plan. RESIDENT 7: Surveyor interviewed Assistant Director K (hire date 05/28/2024) on 10/22/2024 at 12:09 PM. S/he stated Resident 7 was on hospice and had a history of falls. S/he recalled, "Two falls that I'm aware of, when [s/he] would try to toilet [him/herself]...(when) [s/he] was tired or getting out of recliner and it wasn't all the way up right..." On 10/24/2024 at approximately 10:30 AM, Director A provided Surveyor requested portions of Resident 7's record to include the face sheet, current signed/dated ISP, hospice plan of care and visit notes and documentation of falls. When providing the records, Director A said s/he was unable to locate any hospice documentation other than medication changes/orders from March/April 2024. Resident 7's face sheet listed diagnoses to include "Shortness of Breath...Mixed Anxiety Disorder...Memory Change from Deficiency..." Resident 7 resided at the facility from 01/17/2023 - 10/16/2024. Incident reports (IR) documented falls on 05/06/2024, 05/13/2024, 06/29/2024, 07/28/2024 and 08/19/2024 (during a resident to resident altercation.) The 05/13/2024 IR documented the need to properly position Resident 7 in his/her chair with the call light and the 07/28/2024 IR documented the need to "keep Resident in main areas and constantly offer help/redirecting." Resident 7's ISP was dated 07/02/2024. The ISP indicated Resident 7's POA was not activated. It	{N 389}		

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{N 389}	Continued From page 65	{N 389}		

documented Resident 7 ambulated with a cane or a walker and was incontinent. It was only signed by Director A and MCO (managed care organization) staff. It was not signed by Resident 7 or his/her power of attorney acknowledging their involvement in, understanding of and agreement with the individual service plan. The ISP was silent to history of falls, ongoing risk of falls or strategies to prevent falls.

Surveyor interviewed Director A on 10/23/2024 at 4:14 PM. S/he explained when residents receive hospice services, the provider relies on their own ISP based on the hospice plan of care. Director A acknowledged some resident records did not contain hospice visit notes or plans of care. S/he thought the records may have been sent out with the residents when they discharged, but s/he was not certain.

Hospice Director KK emailed Surveyor Resident 7's current hospice plan of care on 10/30/2024. The plan read, "Problem: History of Falls/Fall Risk...History of falls related to dementia." The plan documented 6 falls:

05/13/2024 - quarter size slightly raised bump to back of head
05/27/2024 - hit head on hand rail in hallway, minimal bruising to left knee
06/12/2024 - staff assisted fall, no injury
06/30/2024 - witnessed fall, small skin tear to left elbow discovered 12 hours later.
07/28/2024 - no injury
08/19/2024 - resident to resident altercation, no injury

The hospice plan of care identified areas of intervention including assessment of the environment and appropriate use of assistive

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devices and caregiver compliance with fall prevention strategies.

Surveyor interviewed POA LL on 10/28/2024 at 2:07 PM. Contrary to the ISP, POA LL said s/he is the activated power of attorney for health care. POA LL said s/he was unhappy with the care Resident 7 received at Care Partners. POA LL confirmed Resident 7 was at risk for falls and relied on a walker to ambulate, but said frequently when s/he would visit the walker would not be nearby Resident 7 or anywhere in the room. POA LL was worried staff were moving the walker out of sight, hoping it would deter Resident 7 from trying to get up and ambulate. Surveyor asked POA LL if s/he was involved in an ISP review during July 2024. S/he replied, "I don't know anything about it to tell you the truth."

The Department published a resource for providers titled "Falls in Assisted Living," last revised 02/2022. It read in part, "Falls resulting in serious injury or death continue to occur in assisted living settings. For this reason, the Division of Quality Assurance (DQA) is reminding assisted living providers of the need to identify residents at risk for falls and to implement strategies for falls prevention...Falls prevention begins with identifying those residents who are at risk for falls. A thorough assessment should take place prior to admission and whenever there is a change in the resident's condition...The following factors may predict an individual's likelihood of falling...Diminished level of consciousness or impaired mental status...Incontinence or need for toileting assistance..Impaired gait or balance, including the use of assuasive devices...A history of falls within the past three months...Once risks are identified, the resident's individual service plan (ISP) should contain approaches to prevent

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{N 389}	Continued From page 67 falls from occurring. The following are some examples of interventions...environmental modifications, such as lighting, location of furniture, clear pathways...Anticipation of needs...supervision...Every fall should result in a post-fall assessment to determine the cause of the fall and the need for additional or modified interventions..." Source: https://www.dhs.wisconsin.gov/publications/p00994.pdf 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 389}		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At	N 397		

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least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more.

This Rule is not met as evidenced by:
Based on record review and interviews, the provider did not ensure a qualified resident care staff was present in the Community Based Residential Facility (CBRF) when one or more residents are present in the CBRF.

On 10/12/2024, Caregiver M was the only care staff on duty for at least 1.25 hours to provide care for residents in this facility (building 2) and the sister facility (building 1). Caregiver M left building 2 unattended approximately 10 times to care for residents in building 1.

This is a repeat deficiency. See Statement of Deficiency NCQ011, dated 06/10/2024.

Findings include:

The provider is licensed to serve up to 16 non-ambulatory residents from the following client groups: advanced age, physically disabled, irreversible dementia/Alzheimer's and traumatic brain injury. On 10/22/2024 at 9:15 AM, Surveyor observed a sister facility (building 1) is located on the same campus, across the parking lot. The provider refers to building 2 as their "memory care" building.

Surveyor interviewed Caregiver M on 10/22/2024 at 3:46 PM. Caregiver M recalled the following timeline of events on 10/12/2024:
Caregiver L was working 2nd shift (2:00 PM - 10:00 PM) in building 1 and Caregiver M was working 6:00 PM - 6:00 AM, also in building 1.

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N 397	Continued From page 69 Caregiver J was working 2nd shift in building 2. Caregiver J's 3rd shift relief staff in building 2 did not report. Caregiver J told Caregiver M s/he could not stay to cover 3rd shift in building 2. Caregiver M agreed to stay in building 2 and Caregiver L agreed to stay and cover 3rd shift in building 1. Caregiver L did not stay as agreed. Caregiver M said s/he was left alone to cover both buildings and described it as "hectic." S/he said s/he ran between the buildings at least 10 times in an effort to check the residents. Caregiver M said s/he was alone from approximately 10:00 PM until approximately 2:00 AM when Caregiver N came in. During one of the checks in building 2 s/he found 2 residents incontinent. Caregiver M said after the incident, nobody from management interviewed him/her to ask about the details. S/he said, "It was like it didn't even come up no more. [sic] I don't know, it wasn't important enough I guess." Surveyor interviewed Director A on 10/23/2024 at 8:33 AM. Director A confirmed awareness of the incident and showed Surveyor a text s/he received from Caregiver N on 10/13/2024 at 1:45 AM, reporting concerns a caregiver "abandoned" their shift. At 8:26 AM, Director A replied to Caregiver N, "I am going to make calls and figure out what the [expletive] is going on. I woke up to a ton of text messages and I'm beyond confused." Director A stated to Surveyor, "[Caregiver M] should have never let [Caregiver L] leave." Surveyor asked if Caregiver M is a supervisor and Director A said s/he is not. Director A went on to say, "You can't leave one person, you can't do it." Director A provided Surveyor with a 1 page	N 397		

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N 397	Continued From page 70 handwritten summary dated 10/13/2024 authored by Assistant Director G. The document read in part, "When I arrived to work it was brought to my attention that 2 of the NOCs (3rd shift) didn't show up...No one called or texted me at all about this...[Caregiver M] said [s/he] didn't know that [s/he] was suppose [sic] to call me...[Caregiver L] was in [building 1] and said [s/he] was going to run to the store...and never came back..." The document did not identify how long the building was unattended, if residents were interviewed or assessed to make sure their needs were met or identify actions taken by the provider to ensure future protection of the residents' health, safety and wellbeing. Director A confirmed Assistant Director G's summary was the only documentation completed in response to the incident and said s/he (Director A) did not conduct an investigation. Surveyor asked if s/he knew how long there was only one caregiver for both buildings and s/he did not know. While in the office with Surveyor, Director A looked at timesheet records and said Caregiver J punched out at 10:15 PM, Caregiver L punched out at 10:30 PM and relief staff Caregiver N punched in at 11:45 PM. 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 397		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF	N 408		

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N 408	Continued From page 71 shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, when a psychotropic medication was prescribed on an as needed basis (PRN) the provider did not ensure: (1) The resident's individual service plan (ISP) included the rationale for use and a detailed description of the behaviors which indicate the need for administration of the medication. (2) The administrator or qualified designee monitored at least monthly for the inappropriate use of PRN psychotropic medication, including the presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. Resident 7 was prescribed lorazepam and haloperidol on an as needed basis to manage behaviors associated with anxiety and pain. The provider did not ensure Resident 7's ISP included the rationale for use or a detailed description of	N 408		

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N 408	Continued From page 72 the anxiety or behaviors which indicate the need for the medications. During September 2024, Resident 7 was administered at least one of the medications 18 out of 30 days. Administrator H or a qualified designee did not monitor for the inappropriate use of the medication, for the presence of possible side effects or to determine if the medication was administered contrary to the intended use. Findings include: Prior to the onsite visit, Surveyor reviewed the deficiencies from Statement of Deficiency YU9Z15 dated 04/30/2024; 2 deficiencies were identified related to medication management systems. Special orders issued 06/07/2024 instructed the provider to develop systems to "Monitor and document the rationale for use, detailed description of the behavior, and effectiveness of the use of PRN psychotropic medication as a behavioral intervention." On 10/24/2024, Surveyor reviewed portions of Resident 7's records and on 10/30/2024, reviewed documentation from hospice. Resident 7 was admitted to the facility 01/17/2023 and discharged on 10/16/2024. Resident 7 had diagnoses to include mixed anxiety disorder. S/he was oriented only to person, had impaired long and short term memory and exhibited anxiety, fatigue, forgetfulness and wandering. Resident 1 was prescribed 2 psychotropic medications PRN: haloperidol .5 mg every 6 hours as needed for agitation or nausea and lorazepam .5 mg every 4 hours for anxiety. Surveyor reviewed August, September and October 2024 MARs (through 10/16/2024) and noted the following:	N 408		

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N 408	Continued From page 73 August - PRN lorazepam was administered 19 of 31 days September - PRN lorazepam and/or haloperidol was administered 18 out of 30 days October - PRN lorazepam and/or haloperidol was administered 13 of 16 days Surveyor completed a detailed review of the September 2024 administration of the PRN psychotropic medications and documentation of behaviors. September 2024 "Behavior Monitoring Log" - The log listed 3 groupings of "Targeting Behaviors" and each day there was a prompt to "chart number of episodes" from each group during "AM," "PM," and "NOC" (overnight) shifts. Surveyor noted each target group included a combination of different behaviors and when episodes were charted they did not specify which behavior within the target group was observed or the time of the observed behaviors. --Group 1: "Anxious, Aggressive, Isolation, Exit Seeking" --Group 2: "Unable to sleep, Restlessness" --Group 3: "Sadness, Isolation, Aggressive" The log prompted caregivers to use the observation notes to "chart intensity & duration of behavioral episodes, as well as effectiveness of interventions used." The log also included sections to document side effects, to evaluate if behaviors increased or were controlled and to determine if the resident was stable on current medications or if physician review was needed. Each of those sections were blank and the form did not document which PRN psychotropic medications were prescribed for Resident 7 or their rationale for use. The log was signed by	N 408		

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N 408	Continued From page 74 Administrator H on 09/13/2024 and by Director A on 09/30/2024. Surveyor compared the September MAR with the behavior log and observation notes and noted the following (sections underlined by Surveyor for emphasis): 09/01 at 9:00 AM - lorazepam administered by Assistant Director K for anxiety LOG: target groups 1, 2 and 3 - two episodes each group during the "AM" NOTES: Restless, pacing, anxiety 09/03 at 9:00 AM - both lorazepam and haloperidol administered by Assistant Director K for anxiety/pain LOG: target groups 1, 2 and 3 - two episodes each group during the "AM" NOTES: weeping 09/04 at 8:00 AM - haloperidol administered by Caregiver Z for anxiety LOG: target groups 1, 2 and 3 - two episodes each group during the "AM" NOTES: none 09/05 at 9:30 AM - lorazepam administered by Assistant Director K for "pain/anxiety" LOG:: target groups 1, 2 and 3 - two episodes each group during the "AM" NOTES: none 09/06 at 3:00 PM - haloperidol administered by Caregiver Z for "anxiety" LOG: zero episodes NOTES: none 09/07 at 10:08 AM - lorazepam administered by Assistant Director K for "pain/anxiety LOG: target groups 1, 2 and 3 - two episodes each group during the "AM" NOTES: none 09/08 at 10:00 AM - lorazepam administered by Assistant Director K for "pain/anxiety"	N 408		

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N 408	Continued From page 75 LOG: target groups 1, 2 and 3 - two episodes each group during the "AM" NOTES: none 09/09 at 9:00 AM - lorazepam administered by Assistant Director K for "pain/anxiety" LOG: target groups 1, 2 and 3 - two episodes each group during the "AM" NOTES: "PRN given" 09/10 at 9:00 AM - lorazepam administered by Assistant Director K for "pain/anxiety" LOG: target groups 1, 2 and 3 - two episodes each group during the "AM" NOTES: none 09/11 at 9:00 AM and 2:00 PM - haloperidol administered by Caregiver Z for "anxiety" LOG: target groups 1, 2 and 3 - two episodes each group during the "AM" LOG: target groups 1, 2 - two episodes each group during the "PM" NOTES: none 09/12 at10:00 AM - lorazepam administered by Assistant Director K for "pain/anxiety" LOG: target groups 1, 2 and 3 - two episodes each group during the "AM" NOTES: Really wet, wet clothes, shower washed 09/18 at 10:00 AM - lorazepam administered by Assistant Director K for "pain/anxiety" LOG: target groups 1, 2 and 3 - two episodes each group during the "AM" NOTES: none 09/19 at 9:00 AM - lorazepam administered by Assistant Director K for "pain/anxiety" LOG: target groups 1, 2 and 3 - two episodes each group during the "AM" NOTES Restless, pacing, pull ups in toilet 09/21 at 2:00 PM - both lorazepam and haloperidol administered for "pain/anxiety", same caregiver administered but initials illegible LOG: target groups 1 and 2 - two episodes each group during the "PM"	N 408		

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N 408	Continued From page 76 Notes: none 09/24 at 10:00 AM - lorazepam administered by Assistant Director K for "pain/anxiety" LOG: target groups 1, 2 and 3 - two episodes each group during the "AM" Notes: none 09/25 at 9:00 AM - lorazepam administered by Assistant Director K for "pain/anxiety" LOG: target groups 1, 2 and 3 - two episodes each group during the "AM" Notes: Set off door alarms, PRN given 09/27 at 1:30 PM - haloperidol administered by Caregiver Z for "anxiety" LOG: zero episodes NOTES: none 09/30 at 9:00 AM - lorazepam administered by Assistant Director K for "pain/anxiety" LOG: target groups 1, 2 and 3 - two episodes each group during the "AM" NOTES: none Surveyor noted the following: On 09/06 and 09/27, Caregiver Z documented administration of haloperidol for "anxiety" on the MAR but did not document anxiety or other behaviors on the log or in the notes. On 09/03 and 09/21, haloperidol and lorazepam were administered at the same time without detailed documentation about why both medications were warranted. Assistant Director K routinely administered lorazepam around the same time each morning and each time documented 2 observations from each of the 3 target groups of behaviors. Surveyor also reviewed Resident 7's most recent individual service plan (ISP) dated 07/02/2024. The ISP was silent to administration of PRN psychotropic medications or a detailed rationale for their use. The ISP did not document needs or	N 408		

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interventions for anxiety or pain. The only behaviors in the ISP were exit seeking and aggression towards staff with interventions to redirect, keep busy with activities and keep in eyesight. The ISP was not signed by Resident 7 or his/her legal representative acknowledging their involvement in and agreement with the plan.

Surveyor conducted an interview with Director A on 10/29/2024 at 8:04 AM. S/he explained the provider utilizes the "Behavior Monitoring Log" as the mechanism to review monthly administration PRN psychotropic medications. Director A also confirmed the provider utilizes their own ISP when residents receive hospice services.

Surveyor conducted an interview with Administrator H on 10/30/2024 at 10:00 AM. Surveyor reviewed the following concerns about administration of PRN lorazepam and haloperidol during September 2024 and lack of a review process to determine if the medications were being administered appropriately:
Eighteen (18) of 30 days one or both of the medications was administered. Twice, both medications were given at the same time without documentation to explain why. Twice, the medication was administered when the behavior log documented there were no behaviors. There was a consistent pattern of administration by the same 2caregivers.
The ISP did not include rational for use and a detailed description of the behaviors which indicate the need for administration of the medications.
The reasons for administration on the MAR were vague and frequently documented as "pain/anxiety."
The behavior monitoring log did not provide clear descriptions of the behaviors which prompted

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N 408	Continued From page 78 administration of the medications. The behavior monitoring log did not include evidence it was used to review for the appropriateness of the administration of lorazepam and haloperidol. Administrator H did not provide additional information in response to the concerns. 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 408		
{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	{N 427}		

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{N 427}	Continued From page 79 provider had a posted activity calendar but did not implement it. This is a repeat deficiency being cited for the third time. See Statement of Deficiency (SOD) SOD YU9214, dated 08/16/2023 and SOD YU9Z15, dated 04/30/2024. Findings include: The provider is licensed to serve up to 16 non-ambulatory residents from the following client groups: advanced age, physically disabled, irreversible dementia/Alzheimer's and traumatic brain injury. The provider refers to this facility as their "memory care" building (there is another facility on the same campus.) Prior to the onsite visit, Surveyor reviewed the deficiencies from SOD YU9Z15. A deficiency was identified related to lack of activities. In a notice dated 06/07/2024, the Department issued special orders to work with a consultant to address, "Activity Program -Including how the facility will ensure a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program...Furthermore, the licensee will ensure: (a) activity assessments will be completed (or reviewed and updated) for each resident and will be maintained in each resident's record. Each resident's participation in leisure activities and/or daily activity programming will be documented. (b) develop and provide an activity program based on the interests/needs identified in resident assessments and shall offer residents the opportunity to participate in meaningful social, recreational, and therapeutic programs. (d) for residents with cognitive impairments, behavioral symptoms, physical	{N 427}		

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impairments, or mental health needs, the facility shall arrange a program of daily activities designed to provide interaction and stimulation consistent with the individual capabilities (and needs) of each resident."

Surveyor reviewed the provider's plan of correction (POC) documentation for SOD YU9Z15, provided by Director A on 10/24/2024. It read, "Leisure Time Activities - [Director A]: Training staff on doing activities during the day." The documentation did not contain evidence of activity assessments or staff training on the provision of meaningful activities.

Surveyor interviewed Power of Attorney (POA) FF on 10/22/204 at 9:23 AM. POA FF said, "They have no activities and [Resident 8] is in bed most of the day except to come and eat." Resident 8 subsequently joined the interview. Surveyor asked if activities were offered and s/he shook his/her head, no.

Surveyor interviewed Assistant Director K on 10/22/2024 at 12:09 PM and asked about the provision of activities. S/he replied, "We did pumpkins. It's hit or miss. I tried to when we had more residents, a lot was outside with the summer. It would calm them down instead of wandering. In the afternoon [Resident 7] and [Resident 2] would sit outside and they were calm." Assistant Director K said they've done bingo and "lots of watching movies. A lot of nail care...I'd set their hair." Surveyor asked what Resident 8 enjoys for activities and s/he replied, "[S/he] likes [his/her] TV, [s/he]'s been through a lot in [his/her] life. [S/he] likes watching TV. [S/he] is not really a reader. [S/he] did the pumpkins with us this year." Assistant Director K went on to say Resident 8 had an interest in woodworking and

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working with his/her hands. Assistant Director K said s/he would decide what activity to do based on "the mood in general." Surveyor asked if there was an activity calendar and s/he replied, "It just started in the last 2-3 weeks." Surveyor and Assistant Director K located the posted calendar. Each date listed approximately 3 or 4 activities. Examples include:

Every Monday
Band/Stretch 10:00 AM - 11:00 AM
Chair Exercise 11:00 AM- 12:00 PM
Q&A 1:00 PM - 2:00 PM
Evening Social 6:00 PM - 7:00 PM

Every Tuesday (10/22/2024 was a Tuesday)
Coffee Social & Morning News 9:00 AM-10:00 AM
Book Club 10:30 AM -11:30 AM
Wind Down Walk 6:00 PM-7:00 PM

Assistant Director K said s/he normally works days and there is no book club. S/he said coffee social and morning news is not an actual activity that include staff engagement. Surveyor asked what type of activity wind down walk was and s/he said, "Nothing. I would assume walking." Assistant Director K said s/he has never done a band stretch and commented, "I don't think we have the bands." Surveyor and Assistant Director K were interviewing in the room where the activity supplies were stored, s/he looked around and said there were no bands present. Assistant Director K said, "Some of the stuff they have had was inappropriate for adults in assisted living...this is not a daycare." Assistant Director K said charting of activities just started in this last month and "before that nothing."

Surveyor reviewed Resident 8's record on

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{N 427}	Continued From page 82 10/23/2024 at 11:34 AM. Resident 8 had diagnoses to include major depressive disorder, dementia and brain injury. It did not include an activity assessment. It included a copy of the aforementioned activity calendar for October 2024 only with circles to indicate activity participation. Surveyor noted the following: 10/01 (Tuesday), 10/02, 10/15 - "refused." It did not specify which activities. 10/14 (Monday) and 10/16 - "N/A" The morning activity of coffee and social (or variations to include coffee and news, donuts, game show or polka) were circled on 10/03, 10/04, 10/08, 10/10, 10/11 and 10/13. College football was circled on 10/05, "pumpkins" on 10/09 and evening social on 10/17. No activities were circled after 10/17 Surveyor interviewed Caregiver Y on 10/22/2024 at 3:46 PM and asked if an activity was scheduled for the evening for Resident 8 (who was the only remaining resident.) S/he replied, "[Resident 8] doesn't do many activities. It's been hard up until [Resident 7] left, [Resident 7] was an elopement risk and [s/he] needed 1-1 time...They didn't have activities for them over here (in this building.) We would try to paint [Resident 7 and Resident 3]'s nails. Or movies...it's more of a memory care." Caregiver Y said there was, "No structure, no schedule. We would just try things. We might take [Resident 7] outside to walk." Surveyor interviewed POA LL on 10/28/2024 at 2:07 PM. S/he said Resident 7 recently moved to a new facility and volunteered, "Oh my God, it's 1,000 times better than Care Partners. They have activities, every day, they have schedules they follow...[S/he] can go outside daily if [s/he] wants...It's just so hard to explain how much better it is." POA LL recalled only 1 time during	{N 427}		

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the past 3 months where s/he observed an activity, possibly during September 2024. POA LL said s/he got to know Resident 3 during his/her visits and observed, "[Resident 3] would sit in the dining room in a chair all day long. [Resident 7] would be in [his/her] room or front room, just hunched up."

Surveyor requested Director A provide documentation from Resident 7's record, including all documentation related to activities. Director A provided the documentation on 10/24/2024. An activity assessment was not provided. The 2023 ISP read, "Leisure Time Activities - [S/he] likes to watch TV and watch others listening to music and trys [sic] to participate in activities." The ISP updated 07/02/2024 included identical language. The October 2024 activity calendar was provided. The morning activity of coffee and social (or aforementioned variations) was circled 10/01, 10/03, 10/04, 10/06, 10/10 and 10/11. Bingo and music were circled on 10/02 and 10/09, movie and popcorn on 10/05, band/stretch on 10/07 and pumpkins on 10/08. No activities were circled after 10/11/2024 (Resident 7 moved out on 10/16/2024.)

Surveyor conducted facility visits 3 consecutive days, 10/22, 10/23 and 10/24/2024 and spent time between this facility and the sister facility across the parking lot. During Surveyor's time in this facility, no activities were observed.

On 10/24/2024 at 11:08 AM, Surveyor interviewed Director A. S/he confirmed activity assessments were not completed for any of the residents and no staff training about activities was provided. Director A said the effort to document activities offered or refused was first implemented after

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{N 427}	Continued From page 84 10/07/2024 (4 months after the special orders) when Consulting Agency KK was hired. According to the National Library of Medicine, "...A critical aspect of supporting people with dementia is facilitating their participation in meaningful activities...activity provision for people with dementia goes beyond mere pleasure to meeting fundamental psychological needs...spiritual/religious activities address the need for death preparation; intergenerational activities address the need for intergenerational relationships; re-acquaintance with previously conducted leisure activities addresses the need for a sense of control and to achieve life goals; and pursuit of new leisure activities addresses the need to be creative...Conclusion: We argue for the importance of activity provision for people with dementia to help promote wellbeing among an increasing proportion of older people." Source: https://pubmed.ncbi.nlm.nih.gov/26933079/, retrieval date 11/27/2024. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws N0214 DHS 83.15(3) Administrator Shall Supervise Daily Operations	{N 427}		