STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019044	A. BUILDING: _____ B. WING _____	R-C 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LILAC SPRINGS ASSISTED LIVING LLC	403 ONEIL ST LAKE MILLS, WI 53551

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 09/24/2024, with information obtained through 09/27/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit and 2 complaint investigations at Lilac Springs Assisted Living LLC, a community-based residential facility (CBRF) located in Lake Mills, WI. As a result of the survey, 6 deficiencies were identified. Two deficiencies are repeat deficiencies. See Statement of Deficiency (SOD) S9RD11, dated 06/23/2023, SOD ZOLI11, dated 01/23/2024, and SOD ZOLI13, dated 05/30/2024. Both complaints were substantiated. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 21	{N 000}		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by:	N 164		

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

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N 164	Continued From page 1 Based on record review and interview, the provider did not ensure that the Department was notified of 3 occasions that law enforcement personnel were called to the CBRF as a result of incidents that jeopardized the safety and welfare of residents and employees. Findings include: On 09/24/2024, at approximately 11:00 a.m., Surveyor interviewed Caregiver H. Caregiver H reported that in the last couple of months, law enforcement had been called out to the facility approximately 3 different times due to incidents where Resident 12 was physically attacking staff or engaging in self-injurious behavior that staff were unable to manage. Caregiver H reported that the most recent time law enforcement was out related to a time when Resident 12's family had arrived on site and "screamed" at Former Administrator G. Caregiver H reported that other residents and staff overheard this exchange and were scared for Former Administrator G. On 09/24/2024, Surveyor reviewed Department files for the provider. There was no evidence of self-reports having been submitted related to law enforcement involvement in 2024. At approximately 4:25 p.m., Surveyor interviewed Licensee K. Licensee K reported being aware of at least one time that law enforcement came to the facility, related to an incident where Resident 12's family came to the facility and yelled at and threatened Former Administrator G. Licensee K denied having any police reports related to the incident. After reviewing the regulation related to notifying the Department of law enforcement involvement, Licensee K asked if s/he could have more information about the notification process.	N 164		

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N 164	Continued From page 2 On 09/25/2024, Surveyor reviewed outside records obtained from law enforcement. These records showed 3 different times law enforcement had been on site at the CBRF from 06/10/2024 - 07/26/2024 related to disorderly conduct concerns and Resident 12. These included the following: 1. 06/10/2024 incident: "I responded to the [facility address] regarding a subject who was combative with staff at a facility and was wanting to leave ...I was advised this had been going on all night and [s/he] was now near the front door, but had fallen and was on the ground. Upon arrival I met with the staff, who introduced me to [Resident 12] on the ground ...Fire Dept responded to assist with lift ..." 2. 06/11/2024 incident: "Disorderly [Resident 12] at Lilac Springs. Subject suffers from dementia and was upset over medication issues. Subject was calmed and returned to [his/her] room until scheduled medication delivery ..." 3. 07/26/2024 incident: "...dispatched to an assisted living facility reference an unruly visitor. Subject was warned for [his/her] actions ... [Former Administrator G] called reporting a visitor was causing a disturbance ...Over the last month or two the police department has been called to the facility for [Resident 12] for a number of disorderly conduct type issues ...[Former Administrator G] said numerous times [Resident 12's family] have been rude to staff ...remarks were sexual innuendos or demanding unreasonable requests from staff ...This case is closed with a warning of [Resident 12's family] for disorderly conduct."	N 164		

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N 169	Continued From page 3	N 169		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 12's legal representative, Person X, was immediately notified when Resident 12 experienced an injury that led to emergency medical services (EMS) being called and subsequent transport to the hospital. Findings include: From 09/24/2024 - 09/27/2024, Surveyor conducted a complaint investigation into an allegation of legal representatives not being notified of residents' incidents and injuries. On 09/24/2024, at approximately 11:00 a.m., Surveyor interviewed Caregiver H. Caregiver H reported that Resident 12, when s/he was a resident, experienced frequent falls and behaviors including physical aggression, seeking his/her narcotic medication, and "throwing" him/herself on the floor intentionally from his/her wheelchair. Caregiver H reported that on Resident 12's last day with the provider, s/he was	N 169		

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N 169	Continued From page 4 experiencing behaviors. On that day, s/he threw him/herself out of his/her wheelchair, was assisted back into his/her wheelchair, and proceeded to use his/her wheelchair to run over Resident 5's feet, which s/he reported s/he was aiming for. Caregiver H reported that Resident 12 then smashed his/her head against the wall and asked to have narcotic pain medication. Caregiver H reported Resident 12 had been recently administered his/her scheduled narcotic medications and according to his/her prescription instructions s/he was not able to administer any other narcotic pain medication. Caregiver H reported that when s/he explained this to Resident 12 s/he proceeded to stand up and throw him/herself to the floor. Caregiver H reported s/he called Resident 12's hospice agency, but the person s/he spoke with instructed him/her to contact EMS due to concern of his/her potential injuries. When asked about the injuries s/he sustained, Caregiver H reported that Resident 12 complained of his head and ribs hurting and that s/he was experiencing difficulties breathing. Caregiver H reported that EMS came on site and transported him/her to the hospital. Caregiver H reported that Resident 12 did not return to the facility after this. On 09/24/2024, Surveyor reviewed Resident 12's record. Resident 12 was admitted to the provider on 03/15/2024 until his/her discharge on 07/28/2024. Resident 12's diagnoses included dementia with behavioral disturbance, alcohol abuse and dependence, cannabis abuse and dependence, and generalized anxiety disorder. Resident 12's face sheet documented that Resident 12 did not have an activated power of attorney (POA) for healthcare. Surveyor reviewed Resident 12's observation notes from 04/01/2024 - 07/31/2024 (3 days after s/he was discharged).	N 169		

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N 169	Continued From page 5	N 169		

Surveyor observed that entries were made throughout the notes that indicated existing incident reports, containing titles including, "Incident Report (Fall - Unwitnessed)." Surveyor observed the following observation note entries:

- 07/28/2024 (3:00 p.m.): " ...PLEASE WATCH THRE [sic] DOOR AS RESIDENT IS NOW TRYING TO LEAVE AND STAND WITHOUT ASSISTANCE."

- 07/28/2024 (3:45 p.m.): "resident has constantly tried to stand and has almost fallen [s/he] has now flipped [him/herself] out of [his/her] chair twice. hospice was called and said there is nothing they can do and they would not be coming and that we are to call 911. [Executive Director] and on call were notified, the on call is coming to evaluate the situation."

No other information was documented after this. There was no evidence of an incident report having been created for this incident (which could have potentially contained more information) or evidence that Resident 12's POA was notified about it.

At approximately 1:35 p.m., Surveyor interviewed Caregiver H (who was designated as being in charge). Caregiver H reported s/he was unable to find any other records related to the incident in Resident 12's record. Caregiver H reported that as far as s/he knew, Resident 12's POA was never activated during Resident 12's admission.

On 09/25/2024, at approximately 11:42 a.m., Surveyor interviewed Person X. Person X reported that s/he was Resident 12's activated POA for healthcare before Resident 12 had discharged from the facility. Person X reported

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N 169	Continued From page 6 that s/he had attempted to visit with Resident 12 earlier on 07/28/2024 (day of the incident) but was forced to leave by staff. Resident 12 reported that at some point after s/he left was when Resident 12 fell and was transported to the hospital. Person X reported staff did not contact him/her regarding the incident and s/he discovered it only after being notified by Resident 12's hospice team later that day. On 09/26/2024, Surveyor reviewed advanced directive paperwork for Resident 12, provided by Person X. The paperwork showed that Person X was Resident 12's power of attorney for healthcare, and that Resident 12 became incapacitated on 06/12/2024 (over 1 month prior to the incident). On 09/26/2024, at approximately 3:02 p.m., Surveyor interviewed Licensee K. Licensee K acknowledged Surveyor's concern that there was no evidence of Resident 12's POA having been notified when Resident 12 had fallen, injured him/herself, and was transported to the hospital on 07/28/2024.	N 169		
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.	N 214		

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N 214	Continued From page 7	N 214		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that the administrator supervised the daily operation of the community-based residential facility (CBRF), including resident care needs.

Findings include:

The provider is a nonambulatory CBRF licensed to serve up to 24 residents in the client groups of advanced aged, irreversible dementia/Alzheimer's, and terminally ill.

Example 1 - Daily operation

From 09/24/2024 - 09/27/2024, Surveyor conducted 2 complaint investigations and a verification visit. Both complaints were substantiated and the following concerns were identified:

N0164 DHS 83.12(4)(b) Reporting When Law Enforcement is Called - the Department was not notified of 3 times law enforcement personnel were called to the CBRF due to incidents involving Resident 12's behaviors and conflicts involving Resident 12's family.

N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes - Resident 12's activated power of attorney (POA) for healthcare was not notified when s/he experienced a fall that resulted in him/her being transported to the emergency department and subsequent hospitalization.

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N 214	Continued From page 8 N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes (cited for the fourth time) - the individual service plans (ISPs) for Residents 5, 8, 9, and 10 were not updated in accordance to needs that involved fall risk mitigation, behavior management, outside agency involvement, seizures, and bed rail use. N0431 DHS 83.38(1)(g) Health Monitoring (cited for the second time) - there was no evidence of follow up monitoring in relation to Resident 5's eye concerns, Resident 8's rash, or Resident 9's therapeutic diet N0480 DHS 83.42(3) Access to Resident Records - Caregivers H and N, left in charge in the absence of Administrator L and Manager M from 09/20/2024 - 10/01/2024, did not have access to resident records including admission agreements, medical reports, and medical provider orders - all of which related to concerns identified from the verification visit and complaint investigations. On 09/24/2024, at approximately 4:25 p.m., Surveyor interviewed Licensee K. Licensee K reported that s/he previously had contracted with Former Administrator A, which also included employment with Former Administrator G, up until several weeks ago, and they were supposed to be in charge of running the CBRF's daily operations. Licensee K reported s/he began having problems and noticing they were not following through on things they were supposed to be doing. Licensee K reported that they left the facility with limited notice. Licensee K alleged that Former Administrator G had deleted ISPs for residents before leaving and that Administrator L, who was recently hired, was having to work at creating new ones. Licensee K reported that	N 214		

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Administrator L and Manager M were working to change the facility around.

Example 2 - Misconduct allegation handling

From 09/24/2024 - 09/27/2024, Surveyor conducted two complaint investigations, one of which identified concerns of staff refusing to change incontinent residents.

On 09/24/2024, at approximately 7:30 a.m., Surveyor arrived on site. Caregiver H, who let Surveyor into the building, reported that both staff who were in charge of the facility were on vacation and s/he didn't think s/he could get ahold of them to inform them of Surveyor being on site. Caregiver H reported that the administrator was Administrator L, who had taken over as the executive director approximately 4 weeks ago. Caregiver H reported that the next person s/he would contact would be Licensee K. At that time, Surveyor interviewed Licensee K via phone call. Upon attempting to confirm current administrator information from Department facility files, identifying Former Administrator A as the administrator on file, Licensee K reported that Former Administrator A was not the administrator and was not associated with the facility anymore. Licensee K confirmed that Administrator L and Manager M, who would typically be in charge, were both on vacation and would not be back until next week. Licensee K reported that Caregiver H and Caregiver N, who were shift medication passers, were designated in charge while Administrator L and Manager M were on vacation and could work with Surveyor to get requested resident records. Surveyor asked if either Caregiver H or Caregiver N would be able to access staff records. Licensee K reported they would not and s/he wasn't sure how to handle

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record access when management was gone. After this phone call, Caregiver H confirmed s/he was working first shift but Caregiver N would not be in until second shift.

At approximately 10:05 a.m., Surveyor interviewed Caregiver Q. Caregiver Q reported s/he was aware of an incident that occurred sometime within the last week where Resident 8, who was known to be incontinent, was left in soiled briefs all night. Caregiver Q reported that the morning after it was discovered, there was dried bowel movement residue that had to be "scraped off" Resident 8's skin. Caregiver Q reported s/he heard this from Caregiver H.

At approximately 10:15 a.m., Surveyor interviewed Caregiver V. Caregiver V reported s/he was aware of some instances of residents not being changed throughout the nighttime, as evidenced by observing dried-on fecal matter on residents' skin and incontinence briefs that had been soiled through to the bedsheets. Caregiver V reported that s/he had seen recent occurrences of this with Residents 4, 8, and 11. Caregiver V reported that s/he brought these concerns up to Caregiver H, who was upset about the concerns and said s/he would bring them up to Administrator L when Administrator L got back from vacation.

At approximately 11:00 a.m., Surveyor interviewed Caregiver H. Caregiver H reported that yesterday s/he found Resident 8 soiled when Caregiver W was supposed to have changed him/her and reported having just done so. Caregiver H reported that this occurred during the changing of shifts when Caregiver W was leaving first shift and s/he was beginning second shift. S/he reported that upon entering Resident 8's

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N 214	Continued From page 11	N 214		

room s/he could smell bowel movement, and when s/he went to change him/her, there was bowel movement leaking through the sides of his/her brief, all the way out the back of his/her brief up to his/her back, and through the front of the brief at his/her genitalia area. Caregiver H reported s/he took a picture of the brief out of concern for how much had been leaking out and thought that there seemed to be at least 2 separate bowel movement episodes that had occurred, due to some fecal matter having been dried on and some not. Caregiver H reported s/he intended to show the picture to Administrator L once s/he returned from vacation. Caregiver H reported s/he had to "chip off" most of the bowel movement residue that had dried on Resident 8's skin and had noticed that bowel movement residue on Resident 8's pants was dried on. Due to these factors, Caregiver H reported s/he suspected Resident 8 had been sitting left soiled for awhile.

During this same interview, Caregiver H reported concern of a different instance where Caregiver W refused to help Resident 11 clean him/herself up after s/he experienced a bowel movement in his/her brief. Caregiver H reported that Resident 11 was known to experience bowel movement incontinence at times. Caregiver H reported that approximately 1.5 weeks ago s/he was helping to clean up Resident 11 after a bowel incontinence episode when s/he observed areas of dried fecal matter and asked Resident 11 about it. Resident 11 reported to him/her that Caregiver W had seen earlier that s/he had been incontinent and needed assistance but then left him/her. Caregiver H reported that s/he then asked Caregiver W about Resident 11's changing and Caregiver W reported to him/her that s/he had changed Resident 11, even though s/he did not.

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N 214	Continued From page 12 During this same interview, Caregiver H reported concern of a different instance last week where Caregiver W left Resident 13 to sit on a bedpan for over an hour. Caregiver H reported that s/he discovered this when s/he went to answer Resident 13's call light, and Resident 13 reported that Caregiver W had placed him/her on the bedpan over an hour ago but never returned. Caregiver H reported that Resident 13 had redness of and indents into the skin on his/her backside and based on the appearance of it, it looked like s/he had been on the bedpan for awhile. Caregiver H reported that Resident 13 was known to be a reliable reporter. Caregiver H reported s/he asked Caregiver W about it, who reported s/he had gotten sidetracked with other tasks. Caregiver H reported s/he did not believe this, however, because Caregiver W was sitting in the breakroom when Caregiver H was questioning him/her. During this same interview, Caregiver H reported that Caregiver W was known to not assist with cares and be "very rude" to residents. Caregiver H clarified that when residents have asked Caregiver W for help s/he has heard him/her tell them that s/he didn't have time to help them. Caregiver H reported that Caregiver W had been like this for the entire duration of his/her employment. Caregiver H reported s/he previously brought up concerns of Caregiver W neglecting resident care needs to Former Administrator G but that it didn't seem like anything was done. Caregiver H reported that staff had brought up concerns of Caregiver W neglecting resident cares to Administrator L, and that it seemed like Administrator L was talking to staff to ask for more information about Caregiver W but s/he was not aware of any investigation.	N 214		

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N 214	Continued From page 13 Caregiver H reported that of his/her own accord since Administrator L left on vacation last week s/he had written statements about his/her concerns and slid them under Administrator L's door but would not be able to access them again because his/her office was locked. Caregiver H reported that s/he was not involved in any investigations related to caregiver misconduct nor would have access to any related documentation to provide to Surveyor. At approximately 3:18 p.m., Surveyor interviewed Caregiver N (the other person designated by Licensee K as being in charge in the absence of Administrator L and Manager M). Caregiver N reported s/he was unaware of any caregiver misconduct investigations and did not have access to any related documentation to provide to Surveyor. Caregiver N reported s/he had concerns regarding Caregiver W's neglect of resident cares. Caregiver N reported that during the past morning on 09/21/2024, when s/he and Caregiver N were working, Caregiver W did not conduct any resident cares and did not answer any resident call lights. Caregiver N reported s/he called Licensee K to let him/her know. Caregiver N reported that Licensee K expressed concern and said they would wait until Administrator L returned from vacation to address the concerns. At approximately 3:43 p.m., Surveyor interviewed Licensee K. Licensee K reported s/he was aware of concerns related to Caregiver W but not any specific allegations involving neglecting specific residents. Licensee K acknowledged Surveyor's concern that with Administrator L and Manager M being out (absent since 09/20/2024 and gone until 10/01/2024), in addition to the limited access to records or awareness of any investigation by Caregivers H and N, who were designated in	N 214		

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N 214	Continued From page 14 charge, that there was no way to verify what specific steps were immediately taken to ensure residents' safety or whether an investigation into the neglect allegations was taking place. Licensee K reported s/he understood Surveyor's concern and that s/he thought about contracting another manager/administrator type position for occasions such as this. On 09/26/2024, at approximately 3:02 p.m., Surveyor interviewed Licensee K again. Licensee K reported s/he believed staffs' reports of Caregiver W's instances of neglecting residents and that s/he intended to give him/her a notice not to return to the facility.	N 214		
{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 record review, observation, and interview, the provider did not ensure that the individual service plan (ISP) was updated to	{N 389}		

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{N 389}	Continued From page 15 reflect the needs of Residents 8, 9, 10, and 5. Resident 8's ISP was not updated to reflect approaches to mitigate his/her high fall risk, the smoking assistance s/he required from staff, his/her Broda chair use, and his/her seizures. Resident 9's ISP was not updated to reflect the therapy services s/he was receiving as well as his/her knee brace use. Resident 10's ISP was not updated to reflect his/her bed rail use, right breast wound management, bottom wound management, fall risk, and transfer needs. Resident 5's ISP was not updated to reflect his/her bed rail use, aggressive behaviors, wandering and exit-seeking, hospice involvement, and increased supervision as directed by hospice to mitigate his/her fall risk. This is a repeat deficiency. This is a repeat deficiency. See Statement of Deficiency (SOD) S9RD11, dated 06/23/2023, SOD ZOLI11, dated 01/23/2024, and SOD ZOLI12, dated 05/30/2024. Findings include: Example 1 - Resident 8's fall risk, smoking assistance, Broda chair use, and seizures On 09/24/2024, at approximately 8:30 a.m., Surveyor observed Resident 8 at the dining area seated in a Broda chair, receiving staff assistance to eat breakfast. At approximately 8:40 a.m., while attempting to administer Resident 8 his/her medication, Caregiver H reported that Resident 8 was experiencing a "mild" seizure. Caregiver H was observed to push Resident 8 in his/her Broda	{N 389}		

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{N 389}	Continued From page 16	{N 389}		

chair away from the dining area for privacy, supervise him/her throughout the seizure, and comfort him/her while s/he experienced the seizure. Upon Resident 8's recovery, approximately 1 minute later, Surveyor interviewed Caregiver H. Caregiver H reported that Resident 8 was known to have mild seizures, the onset of which were identified from Resident 8 starting to stare without focus. Caregiver H reported s/he wasn't sure if other staff were familiar with handling Resident 8's seizures.

At approximately 9:45 a.m., Surveyor observed Caregiver Q out on the facility's back patio with Resident 8. Caregiver Q was sitting with Resident 8 and appeared to be helping him/her smoke his/her cigarette.

On 09/24/2024, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider on 03/28/2024 with diagnoses including Parkinson's disease and seizures. Resident 8 was documented as receiving hospice services and had an activated power of attorney for healthcare. Resident 8's observation notes, dated 07/01/2024 - 09/24/2024, documented the following:

- 07/01/2024 (11:30 a.m.): "Resident is unable to smoke cigarettes by [him/herself], requires assistance to bring them to mouth and too [sic] ash."

Surveyor reviewed Resident 8's current ISP, provided by Caregiver H and not dated, and observed the following:

- Under the "Ambulation - 2 person assist" heading: "Resident is non-ambulatory. When moved, staff uses a mechanical lift."

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{N 389}	Continued From page 17 - Under the "Fall Risk - High" heading: "Tenant is a fall risk. [Specify instructions for staff[[sic]. Resident has been identified as a fall risk." There was no information in the ISP about Resident 8's Broda chair use, required assistance and supervision for smoking, or information about his/her seizures and seizure-related protocols that staff followed for him/her. Although the ISP identified Resident 8 as being a high risk for falls, no approaches or interventions were identified to mitigate this risk. Example 2 - Resident 9's therapy and knee brace On 09/24/2024, Surveyor reviewed Resident 9's record. Resident 9 was admitted to the provider on 12/12/2022 with diagnoses including moderate intellectual disabilities. Resident 9 was documented as having a legal guardian. Surveyor reviewed Resident 9's ISP, provided by Caregiver H and not dated, and observed the following: - Under the "Lilac - Therapy" heading: "Resident is enrolled with [therapy agency] for [physical therapy], [occupational therapy], and [speech therapy]. Facility to receive updates from agency, and staff to implement recommendations for resident care." Surveyor reviewed Resident 9's observation notes, dated 07/01/2024 - 09/24/2024, and observed the following: - 08/01/2024 (12:00 p.m.): "[Resident 9] has been fitted for a Drytex Hinged Brace for the right knee. [S/he] is to have it put on first thing in the morning prior to getting out of bed. The hole on the Velcro side should be placed over the knee cap. [S/he]	{N 389}		

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{N 389}	Continued From page 18 will wear the brace until after lunch and then have it taken off for 2-3 hours. Should be put back on prior to dinner. [Resident 9] is to wear the brace with walking for improved knee stability." - 08/16/2024 (11:45 a.m.): "Admitted to homecare. [Physical therapy] will see [him/her] 2x per week to start. Working on strengthening and bed mobility/gait training. Please encourage PT strengthening routine ..." Upon reviewing Resident 9's ISP again, Surveyor did not observe any information about Resident 9's knee brace, including a wear schedule. On 09/25/2024, at approximately 3:23 p.m., Surveyor interviewed Nurse Case Manager Q, from Resident 9's managed care organization (MCO). Nurse Case Manager Q confirmed that Resident 9 was working with physical therapy, but s/he was unaware of any time that Resident 9 had worked with speech therapy or occupational therapy. Nurse Case Manager Q reported that while speaking with Surveyor s/he was reviewing Resident 9's authorizations and couldn't see any time that the MCO had authorized any kind of speech or occupational therapy for Resident 9. Example 3 - Resident 10's bed rail use, right breast wound management, bottom wound management, fall risk, and transfer needs On 09/24/2024, at approximately 9:10 a.m., Surveyor observed Caregiver H prepare to administer Resident 10's ointments. Caregiver H wheeled Resident 10 in a manual wheelchair to his/her room. While Caregiver H was gathering supplies in Resident 10's room, Resident 10 transferred him/herself from his/her wheelchair to his/her lift recliner. Caregiver H then conducted	{N 389}		

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wound care to a skin wound on Resident 10's right breast area. Caregiver H removed a dressing from Resident 10's breast, which contained dried blood. The wound appeared to be in a curved shape, approximately 5 cm in length by 2 cm. The wound contained open areas, was varying degrees of red and pink, and appeared to be draining. Caregiver H confirmed that the wound was a complication of cancer. Caregiver H confirmed that the wound had been present for approximately the past 6 months, and the bleeding/drainage had been occurring for approximately the last 1-3 months. Caregiver H confirmed that staff conducted daily dressing changes with saline application, but Resident 10's hospice staff also monitored the wound. Caregiver H was observed applying a fluid, which s/he confirmed was saline, around Resident 10's breast wound, then applying an ointment to the wound, and then applying a dressing to cover the area. While in Resident 10's room, Surveyor observed a bed with 2 bilateral quarter rails in the "up" position on Resident 10's bed.

At approximately 9:48 a.m., Surveyor interviewed Nurse S, who was part of Resident 10's hospice team. Nurse S reported that Resident 10 was admitted to hospice on 06/10/2024. Nurse S reported that Resident 10 experienced difficulties with perineal cares after voiding, and with this and Resident 10 sitting often throughout the day, s/he had known history of skin breakdown to his/her bottom. Nurse S reported that this ranged from stage 1 (typically a reddened area of skin) to stage 2 (development of blister or open sore). Nurse S denied that this was being managed with any sort of dressings but reported that Resident 10 self-applied an ointment to his/her bottom.

On 09/24/2024, Surveyor reviewed Resident 10's

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record. Resident 10 was admitted to the provider on 12/12/2022 with diagnoses including history of malignant skin melanoma. Resident 10's observation notes, dated 07/01/2024 - 09/24/2024, documented entries on 07/25/2025, 08/06/2024, 08/10/2024, and 09/16/2024 with occurrences where staff detailed conducting wound care to Resident 10's right breast. Surveyor reviewed Resident 10's ISP, provided by Caregiver H and not dated, and observed the following:

- Under the "Fall Risk - High" heading: "Tenant is a fall risk. [Specify instructions for staff[[sic]. Resident has been identified as a fall risk."

- Under the "Nursing Procedures" heading: "Wound care instructions are provided by hospice [registered nurse]."

- Under the "Transferring - 1 person assist" heading: "Resident requires hands on assistance of one staff member." Under a different heading, "Lilac- Transferring" the following was documented: "Resident is able to transfer independently; [s/he] may need assistance on days of not feeling well or increased weakness."

- Under the "Lilac- Wound Care" heading: "per Palliative care team staff should assist resident with cleaning [his/her] bottom. Resident has sores on [his/her] bottom. Staff should assure that wounds are covered and bandages are clean. If bandages are soiled please replace bandages."

The ISP identified inconsistent needs related to Resident 10's transfers that were not clarified (requiring "hands on" assistance" in one section and being labeled as independent in another). Although the ISP identified "wound care

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{N 389}	Continued From page 21 instructions", it did not identify known wound monitoring and management specific to Resident 10's right breast. Although the ISP identified Resident 10 as being a high risk for falls, no approaches or interventions were identified to mitigate this risk. The ISP was not updated with current information regarding Resident 10's bottom wound management, which was no longer actively managed with bandages/dressings. The ISP did not contain information regarding Resident 10's bed rail use. At approximately 12:24 p.m., Surveyor interviewed Caregiver H. Caregiver H confirmed that there were paper records maintained as part of residents' records, which maybe included medical notes or other medical-related reports brought in from outside agencies. Caregiver H reported that these records were located in the management office, which was locked while Administrator L and Manager M were on vacation from 09/20/2024 - 10/01/2024. Caregiver H reported that staff did not have access to the locked office. Example 4 - Resident 5's aggressive behaviors, wandering and exit-seeking, bed rail use, hospice involvement, and increased supervision as directed by hospice to mitigate his/her fall risk On 09/24/2024, at approximately 10:43 p.m., Surveyor interviewed Caregiver Q. Caregiver Q identified Resident 5 as someone who has had multiple falls in recent months, typically related to him/her trying to get up and transfer him/herself on his/her own. Caregiver Q reported that staff had been using a bed alarm for awhile but about 2 weeks ago also began using an alarm that could clip onto him/her while seated.	{N 389}		

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{N 389}	Continued From page 22 At approximately 2:15 p.m., Surveyor interviewed Resident 5 and Family Member T, who identified him/herself as Resident 5's activated power of attorney for healthcare. Family Member T reported that Resident 5 had been receiving hospice services since approximately July 2024. Family Member T reported that Resident 5 had experienced multiple falls since s/he was admitted to the provider and that in the last month alone s/he experienced approximately 3 or 4 falls, one of which involved a response from emergency medical services due to concerns of Resident 5 experiencing a potential concussion. Family Member T reported that staff had recently been using both a bed alarm, when Resident 5 was in bed, and an alarm that attached to him/her while s/he was seated, to alert staff to Resident 5 because s/he was known to attempt to self-transfer without the staff assistance that s/he required. Family Member T reported that Resident 5 was known to unplug the bed alarm. Family Member T reported that approximately 1 week ago staff had found Resident 5 on the floor and discovered Resident 5 had unplugged his/her own bed alarm and gotten up out of bed. As a result of that fall, Resident 5 sustained a "rug-burn" type rash on his/her right-sided head and right lower extremity as well as swelling of his/her right eye area and right hand. During this interview, Surveyor observed an area of pink skin, consistent in appearance with newly-healed skin, at Resident 5's right forehead. During the interview, Family Member T also reported that Resident 5 had been experiencing behaviors for the last couple of months that they were trying to manage. These behaviors included hitting out at staff, yelling at staff, and one occurrence of kicking staff.	{N 389}		

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{N 389}	Continued From page 23 While interviewing Resident 5 and Family Member T, Surveyor observed bilateral quarter bed rails, both in the up position, on Resident 5's bed. Family Member T reported that these were typically up and s/he thought Resident 5 used them to assist in getting him/herself up out of bed. On 09/24/2024, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider on 10/25/2023. Surveyor reviewed Resident 5's observation notes, dated 07/01/2024 - 09/24/2024, which documented the following occurrences of Resident 5 refusing his/her cares or demonstrating "aggressive" behaviors: - 07/17/2024 (3:45 a.m.): " ...Writer tried getting resident back to resident's room but resident yelled at writer and another staff member ...Writer tried putting residents [sic] depend on and resident kicked and hit writer. Also when writer tried putting the depend on resident, resident snatched depend out writers [sic] hand and threw it across the hall ...resident grabbed writers wrist and was pulling and squeezing. Another entry at 6:00 a.m. documented, " ...was being aggressive over staff and not let staff changed [sic] resident. Resident refused any care." Another entry at 11:15 a.m. documented, "Resident refused to get dressed and changed. Staff gave [him/her] time and came back again and resident let [him/her] changed [sic] ..." - 07/19/2024 (10:45 a.m.): "Resident did not want anyone in [his/her] room when [s/he] was checked on, forced staff to leave. Resident was confused and did not let staff change [him/her]." Another entry at 11:00 a.m. documented, "Resident refused getting changed this morning. Being aggressive over staff."	{N 389}		

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{N 389}	Continued From page 24 - 07/20/2024 (12:15 p.m.): "Resident refused getting changed and was telling staff to get out of [his/her] room. Staff tried several times but [s/he] kept refusing. Staff tried with a different staff but resident didn't let [him/her] either." - 07/24/2024 (10:45 a.m.): "Resident refused getting changed into clean clothes. Resident pants was soak [sic]. Resident was aggressive over staff about getting [him/her] changed, and kick staff out of [his/her] room. Staff attended several times, but still refused. After a while Resident let other staff changed [sic] [him/her]." - 07/26/2024 (11:00 a.m.): "Resident refused getting a shower by hospice. Resident refused getting dressed and changed [his/her] depend this morning, staff tried again after breakfast." - 07/27/2024 (9:00 a.m.): " ...being aggressive towards staff." - 07/29/2024 (8:30 a.m.): " ...Hospice tried to get [him/her] in the shower [s/he] started being aggressive with hospice and staff ..." - 07/30/2024 (6:45 a.m.): " ...Refused get changed into cleaned [sic] clothes and depend. Another staff tried this morning and nothing. Resident get a little aggressive over staff while trying to changed [him/her]." - 08/06/2024 (7:00 p.m.): "Resident refused shower ..." - 08/11/2024 (12:30 p.m.): "[Resident 5] has been very agitated today. Early before breakfast [s/he] had started yelling at staff and calling staff names ...[S/he] continues to be very agitated and	{N 389}		

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confused and continues to call staff names."

- 08/12/2024 (9:45 a.m.): " ...Also, [s/he] was being aggressive with the residents and staff."

- 08/21/2024 (7:30 p.m.): "Resident refused shower."

- 08/28/2024 (10:45 a.m.): " ...Resident is attempting to bite staff. [S/he] is refusing most cares. And becoming more physically and verballly [sic] abusive towards staff. [S/he] also threatened to punch [unidentified resident]. We removed both from situation." Another entry at 11:00 a.m. documented, "The resident is agitated with staff because the resident keeps grabbing onto staff inappropriately and saying that staff doesn't do anything ...The writer got [his/her] har [sic] pulled by the resident and the resident just tried choking the writer."

- 09/04/2024 (3:45 p.m.): " ...resident was being combative towards staff member."

Surveyor reviewed Resident 5's ISP, provided by Caregiver H and not dated, but did not observe any information related to Resident 5's aggressive and care refusal behaviors, or staff's management of them

In reviewing the observation notes, Surveyor also observed multiple occurrences of Resident 5 wandering into others' rooms and exit-seeking documented, including the following:

- 07/17/2024 (3:45 a.m.): " ...Resident was also trying to go into other residents [sic] rooms ..."

- 07/26/2024 (10:00 p.m.): "Resident tried to escape multiple times staff tried to redirect

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[him/her] didn't work just tried more times to escape then [s/he] tried going in residents [sic] room trying to find away [sic] out ..."

- 07/27/2024 (9:00 a.m.): "Resident door seeking and wander [sic]. 3 staff member stood by the front door because resident is trying to get out ..." Another entry at 12:15 p.m. documented, "Resident still wandering and door seeking ..."

- 07/29/2024 (10:30 a.m.): "resident was confused, wandering and exit seeking. resident was accompanied by staff but was able to make it out the back door. Staff was able to redirect resident inside ..." Another entry at 6:15 p.m. documented, " ...[S/he] has been wandering into other resident's rooms ..."

- 07/30/2024 (6:45 a.m.): " ...Resident was getting into residents [sic] rooms ..."

- 08/12/2024 (9:45 a.m.): " ...The resident was up and walking around and trying to get into residents [sic] rooms ..."

Surveyor reviewed Resident 5's ISP for wandering, exit-seeking, and elopement attempt behaviors, which documented the following:

- Under the "Risk - Elopement" heading: "Resident has been identified as an elopement risk."

- Under the "Risk - Wandering" heading: "Resident has been identified as a wandering risk, but has no previous occurrences of elopement."

There was no information about the extent of Resident 5's wandering and exit-seeking, staff's

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management of those behaviors, or approaches/interventions to mitigate the elopement risk that Resident 5 was documented as having.

In reviewing the observation notes, Surveyor also observed 2 flagged incident reports for Resident 5 - one on 09/08/2024 and one on 09/17/2024 that both were titled "Fall (Unwitnessed). Surveyor reviewed Resident 5's ISP for information regarding his/her fall risk and fall risk mitigation interventions, which documented that as of 09/11/2024 staff were using a chair and bed alarm with him/her to alert staff "when [s/he] has positioned outside the safe area." The ISP did not document information about Resident 5's behaviors of unplugging his/her own bed alarm.

On 09/25/2024, Surveyor reviewed the above incident reports, provided by Licensee K, which documented the following:

- 09/08/2024 (4:14 p.m.): "Staff went to go check on resident and [s/he] was on the floor between the bed and wall staff was able to get [him/her] of [sic] the floor."

- 09/18/2024 (which documented the fall that occurred on 09/17/2024 around 12:34 p.m.): "Resident was found face down on right side. [S/he] has some injuries to the face breast leg and arm on the right side along with a badly swollen ey [sic]."

In reviewing the observation notes again, Surveyor observed an entry on 09/17/2024 at 11:00 a.m. (seeming to correlate with the 09/17/2024 fall documented above): "Talking with hospice we need to do 15 min checks and we need to bring [him/her] out to the common area

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{N 389}	Continued From page 28 so we can keep any eye on [him/her] ..." Resident 5's ISP did not identify Resident 5 has being involved with hospice or this new direction from his/her hospice team - the most recent safety check approach from the ISP documented that as of 10/23/2023 staff would "perform safety checks at least every two hours by setting eyes on the resident. Two-hour checks will continue through each shift." Resident 5's ISP also did not contain information regarding his/her bed rail use. INTERVIEW: On 09/26/2024, at 3:02 p.m., Surveyor interviewed Licensee K regarding the above concerns with ISPs. Licensee K confirmed understanding Surveyor's concerns and reported that Administrator L was in the process of re-creating them due to Previous Administrator G having deleted all previous ISPs for residents. Licensee K reported that s/he was taking notes to follow up with staff.	{N 389}		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical	N 431		

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N 431	Continued From page 29 health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure the health of Residents 5, 8, and 9 was monitored. On 07/16/2024, 08/25/2024, and 09/08/2024, Resident 5 was documented as experiencing changes in his/her eye condition including various symptoms of pinkness/redness, pus presence, and swelling - follow up monitoring of which was not documented in between these instances or after 09/08/2024. On 09/18/2024, staff documented the emergence of a rash-like change on Resident 8's right breast and right-sided stomach, follow up monitoring of which was not documented after its onset.	N 431		

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N 431	Continued From page 30 Inconsistencies of Resident 9's therapeutic diet was both in his/her record and applied based on observations of the fluids staff provided to him/her. Resident 9 was documented as having dysphagia, being a high risk for choking, and having experienced a choking incident which required the Heimlich maneuver to be performed by staff on 08/14/2024. Staff did not have access to a medical provider order or medical reports that directed specific current dietary recommendations for Resident 9 by a medical provider or clinician. Resident 9's ISP directed for him/her to have honey-thickened fluids, which was inconsistent with Caregiver H's report that Resident 9 required nectar-thickened fluids, inconsistent with the most recent medical provider direction on 07/10/2023 (obtained from outside interview) that directed for him/her to have nectar-thickened fluids, and inconsistent with other documents in his/her record that documented s/he was supposed to have "mildly thick" fluids. In addition, interview identified that staff were not routinely thickening all of Resident 9's liquids, such as the drinks s/he was known to obtain him/herself from his/her personal refrigerator as well as water provided by staff during routine water passes. Observation of 2 meals identified that staff did not thicken Resident 9's breakfast water and lunchtime juice, the reason for which being, as reported by Caregiver H, that Resident 9's thickening powder was out as of 09/23/2024 and would not be delivered until 09/26/2024. Although staff reported understanding that use of a safe sip straw for Resident 9 could be an alternative to thickening his/her fluids, Nurse Case Manager R denied awareness of this and there was no evidence that this recommendation was made or endorsed by a medical provider or clinician.	N 431		

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N 431	Continued From page 31 This is a repeat deficiency. See Statement of Deficiency (SOD) ZOLI11, dated 01/23/2024. Findings include: Example 1 - Resident 5's eyes On 09/24/2024, at approximately 7:30 a.m., Surveyor arrived on site. At that same time, Surveyor interviewed Licensee K via phone call. Licensee K reported that Caregiver H, who was a shift medication passer, was designated in charge while Administrator L and Manager M were on vacation and could work with Surveyor to get requested resident records. On 09/24/2024, at approximately 2:00 p.m., Surveyor interviewed Caregiver H. Caregiver H reported needing to leave due to it being the end of his/her shift and provided Surveyor with Resident 5's observation notes, which s/he confirmed was where staff charted resident information and updates. Caregiver H confirmed s/he would be available the next day, 09/25/2025, during his/her scheduled first shift, from approximately 6:00 a.m. - 2:00 p.m., to continue the survey process and provide any additional information or records that Surveyor needed. Caregiver H acknowledged Surveyor's concern that additional records and information would be needed upon request on 09/25/2024. Caregiver H confirmed the facility's phone number as the contact number for Surveyor to follow up with. On 09/24/2024, at approximately 2:15 p.m., Surveyor interviewed Family Member T, who identified him/herself as Resident 5's activated power of attorney (POA) for healthcare. Family Member T reported that Resident 5 had been	N 431		

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receiving hospice services since approximately July 2024.

On 09/25/2024, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider on 10/25/2023. Resident 5 individual service plan (ISP), provided by Caregiver H on 09/24/2024 and not dated, did not identify any health monitoring needs. Surveyor reviewed Resident 5's observation notes from 07/01/2024 - 09/24/2024 and observed an entry on 07/16/2024 (6:30 p.m.), which documented, "While writer was giving resident a shower writer noticed that resident had a lot of puss [sic] in resident's eye and its [sic] a little pink." There was nothing else documented regarding Resident 5's eye until an entry on 08/25/2024 (9:45 p.m.), over 1 month later, documented, " ...[his/her] eyes are very goopy and very red. Hospice was called and came out to evaluate the resident. [S/he] stated that we need to use refresh eye drops and keep an eye on things." There was nothing else documented regarding Resident 5's eyes or staff's monitoring of them until an entry on 09/08/2024 (3:00 p.m.), 2 weeks later, which documented, "Went to change a resident and [his/her] left eye is swollen and [his/her] left ear and [his/her] right eye there is a little puffy going on hospice was called and they say to put a cold compress on it [Administrator L] was notified as well." Nothing else was documented regarding Resident 5's eyes after these 3 occurrences, including any further assessment, monitoring, or resolution of his/her eye concerns.

Throughout the day on 09/25/2024, Surveyor attempted to contact Caregiver H for additional information regarding Resident 5's eye concerns. Upon Surveyor calling at 11:10 a.m., the call was not answered. At 11:39 a.m., Surveyor called the

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facility phone number again. Caregiver H answered but reported s/he was in the middle of medication pass and would not be able to talk to Surveyor until 1:00 p.m. when s/he would call Surveyor back. At 1:15 p.m. and 1:23 p.m., Surveyor attempted to interview Caregiver H again but the phone calls were not answered. No further contact or follow up information was received by Surveyor from Caregiver H.

Example 2 - Resident 8's rash

On 09/24/2024, at approximately 7:30 a.m., Surveyor arrived on site. At that same time, Surveyor interviewed Licensee K via phone call. Licensee K reported that Caregiver H, who was a shift medication passer, was designated in charge while Administrator L and Manager M were on vacation and could work with Surveyor to get requested resident records.

On 09/24/2024, at approximately 2:00 p.m., Surveyor interviewed Caregiver H. Caregiver H reported needing to leave due to it being the end of his/her shift and provided Surveyor with Resident 8's observation notes, which s/he confirmed was where staff charted resident information and updates. Caregiver H confirmed s/he would be available the next day, 09/25/2025, during his/her scheduled first shift, from approximately 6:00 a.m. - 2:00 p.m., to continue the survey process and provide any additional information or records that Surveyor needed. Caregiver H acknowledged Surveyor's concern that additional records and information would be needed upon request on 09/25/2024. Caregiver H confirmed the facility's phone number as the contact number for Surveyor to follow up with.

On 09/25/2024, Surveyor reviewed Resident 8's

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record. Resident 8 was admitted to the provider on 03/28/2024, was documented as receiving hospice services, and documented as having an activated POA for healthcare. Resident 8's ISP, provided by Caregiver H on 09/24/2024 and not dated, did not identify any health monitoring needs. Surveyor reviewed Resident 8's observation notes from 07/01/2024 - 09/24/2024 and observed an entry on 09/19/2024 (1:30 p.m.) which documented, "Resident has something like a rash on right breast and right side of stomach." Nothing else was documented regarding this change in Resident's skin, including any further assessment, monitoring, or resolution of the rash-like onset.

Throughout the day on 09/25/2024, Surveyor attempted to contact Caregiver H for additional information regarding Resident 8's rash concerns. Upon Surveyor calling at 11:10 a.m., the call was not answered. At 11:39 a.m., Surveyor called the facility phone number again. Caregiver H answered but reported s/he was in the middle of medication pass and would not be able to talk to Surveyor until 1:00 p.m. when s/he would call Surveyor back. At 1:15 p.m. and 1:23 p.m., Surveyor attempted to interview Caregiver H again but the phone calls were not answered. No further contact or follow up information was received by Surveyor from Caregiver H.

Example 3 - Resident 9's inconsistent application of his/her therapeutic diet

On 09/24/2024, at approximately 9:27 a.m., Surveyor observed Caregiver H administer Resident 9 his/her medications. Resident 9 was seated at a table in the dining area finishing breakfast, which included a cup of fluid consistent in appearance with water. Surveyor observed a

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straw in Resident 9's cup, which had a widened lower half. Caregiver H reported that this was a straw specific to Resident 9 that could limit the amount of liquid s/he could suck up from the cup. Caregiver H reported that Resident 9 typically required his/her fluids to be thickened, but staff ran out of his/her thickening agent last night and so they were using the straw to help mitigate his/her choking risk. Caregiver H reported that Resident 9's thickening agent was scheduled to be delivered on Thursday (09/26/2024, 2 days later).

At approximately 11:00 a.m., Surveyor interviewed Caregiver H regarding medical record access. Caregiver H reported that some resident records were maintained in residents' paper files, located in the management office. Caregiver H reported that the office was locked and s/he did not have access to it. Caregiver H reported that Administrator L and Manager M, who had access to the office, had left on 09/20/2024 and weren't returning until 10/01/2024. When asked where medical reports for residents, including doctor's visit notes, hospitalization records, and emergency department records, were maintained, Caregiver H reported that that paperwork was typically given to management but s/he was not sure where those records would be located.

At approximately 12:41 p.m., Surveyor observed Resident 9 finishing lunch. Liquid, consistent in appearance with juice, was in Resident 9's cup and his/her straw was in the cup. Kitchen Staff O confirmed that Resident 9 was served regular juice without thickening agent. Kitchen Staff O reported that Resident 9 using his/her special straw meant there was no need for his/her fluids to be thickened.

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N 431	Continued From page 36 On 09/24/2024, Surveyor reviewed Resident 9's face sheet from his/her electronic record, which identified that s/he was on a therapeutic diet that consisted of pureed foods and "mildly thick" fluids. Resident 9's diagnoses included moderate intellectual disability, complete loss of teeth, and dysphagia (difficulty swallowing). A list of orders for Resident 9 showed an order for "Thick-it Powder" active as of 01/18/2023 with the instructions, "Use as directed to thicken liquids." Resident 9's observation notes documented an entry 08/14/2024 at 12:45 p.m. that staff had to perform the Heimlich maneuver on him/her during lunch due to Resident 9 "coughing profusely", his/her face reddening, and subsequently stopping breathing and coughing. Resident 9's ISP, provided by Caregiver H and not dated, contained the following information regarding Resident 9's therapeutic diet and choking: - Under the "Lilac - Dietary" heading: " ...Resident is a pureed diet and honey thickened liquids = [s/he] must be monitored while eating ..." - A heading for "Lilac - Water pass" also documented, "Thicken water/slow sip straw." - Under the "Risk - Choking" heading: "Resident has been identified as a high choking risk." - Under the "Eating - As Needed Assistance" heading: "Resident is able to feed [him/herself] but needs cueing to take small bites, chew, take breaks, and not rush. [S/he] also needs reminders to keep [his/her] chin tucked while swolling [sic], as this seems to help [him/her]. [S/he] is a choking/aspiration risk, so does need to eat meals in the dining room to be monitored. [S/he] is pureed diet with honey thickened	N 431		

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N 431	Continued From page 37 liquids." Surveyor did not observe any information in Resident 9's ISP indicating that Resident 9 did not require his/her fluids to be thickened if s/he was using his/her safe sip straw or documenting the thickened fluids/straw use as mutually exclusive "either/or" needs. At approximately 1:45 p.m., Surveyor interviewed Caregiver H and requested the medical provider orders for Resident 9's diet. Caregiver H showed Surveyor a document from the provider's electronic record platform, titled "Physician Order Sheet" which showed the same information as Resident 9's face sheet - that s/he was to receive pureed foods and "mildly thick" fluids. There was no evidence of these recommendations having been made by a medical provider or clinician as the document was produced by the provider's electronic record platform and not signed. Caregiver H clarified that the "mildly thick" fluid direction meant that Resident 9's fluids to be thickened to a nectar, not honey, level. Surveyor observed that this was a different level than what was specified in Resident 9's ISP. Caregiver H reported that Resident 9 has always had a safe sip straw, and in the occurrences when s/he is out of thickening powder, staff ensure s/he uses the straw for all drinks. Caregiver H also reported that when staff thickened Resident 9's fluids, they only thickened his/her mealtime fluids. Caregiver H reported that Resident 9 had drinks, including soda, stored in a fridge in his/her room that s/he had access to and drank which were not thickened. Caregiver H also reported that staff routinely conducted water passes during shifts and that water provided to Resident 9 during these passes was also not thickened, but that Resident 9 also maintained his/her safe sip straw	N 431		

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N 431	Continued From page 38	N 431		

in his/her room so that was what s/he used to drink water provided by staff in addition to the drinks from his/her own room. Surveyor requested from Caregiver H any dietary orders or medical notes in Resident 9's record in order to verify that the inconsistent application of Resident 9's fluid thickening was directed or endorsed by a medical provider or clinician. Caregiver H reported s/he was unable to find any dietary orders in Resident 9's electronic record and again confirmed s/he did not have access to any files located in management's office. Caregiver H reported s/he was unsure if Resident 9's medical provider was aware of or approved of the safe sip straw use in place of thickening Resident 9's fluids.

On 09/25/2024, at approximately 11:12 a.m., Surveyor interviewed Nurse U, from the clinic listed in Resident 9's record as being his/her current primary care provider. Nurse U reported that Resident 9 had been a patient of the current clinic since July 2023 (over 1 year ago). Nurse U reported s/he was unable to find any information regarding Resident 9's dietary needs, including the needs, orders, or recommendations for any therapeutic diets, in Resident 9's medical record. Nurse U reported that Resident 9 had no orders (past or active) for swallow studies and no swallow study results on file.

At approximately 11:26 a.m., Surveyor interviewed Patient Representative P, from the clinic of the medical provider documented as having ordered Resident 9's "Thick-it Powder" above. Patient Representative P reported that Resident 9 was no longer an active patient as part of that clinic, as of July 2023, and that the thickener powder order that was in Resident 9's order set would be an old and expired order.

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Patient Representative P reported that the last note s/he could see was a communication message from Resident 9's current medical provider on 07/10/2023 (over 1 year ago), which instructed for Resident 9 "to continue nectar thick liquids until re-evaluated by speech therapy."

At approximately 3:23 p.m., Surveyor interviewed Nurse Case Manager R, from Resident 9's managed care organization (MCO). Nurse Case Manager R reported s/he could not see any authorization for speech therapy services since Resident 9 had been with the provider. Nurse Case Manager R reported that the last assessment conducted by an MCO nurse case manager was on 06/05/2024 (before s/he had been involved in Resident 9's care), which documented that Resident 9 was supposed to have honey-thickened fluids and pureed foods. Nurse Case Manager R reported that Resident 9's use of the safe sip straw began approximately on 08/20/2024 when it was suggested by the ombudsman during a team meeting. Nurse Case Manager R reported that the safe straw use was not discussed during the meeting as intended to be used in lieu of the thickener but presented as an option to limit the amount of fluid Resident 9 was able to intake at one time. Nurse Case Manager R reported s/he was unaware of any recommendation made that staff could use Resident 9's safe sip straw as an alternative to thickening his/her fluids and that his/her understanding was that all of Resident 9's fluids were supposed to be thickened.

According to the International Dysphagia Diet Standardization Initiative (IDDSI), an internationally recognized initiative in the standardization of therapeutic diet recommendations, nectar-thick and honey-thick

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fluids are different consistencies both as recognized by IDDSI and the National Dysphagia Diet (NDD). Nectar-thick fluids from the NDD standards are consistent with "mildly thick" fluids on the IDDSI standards. Honey-thick fluids from the NDD standards are consistent with "moderately thick" fluids on the IDDSI standard (Source: IDDSI, Common ground between NDD and IDDSI, July 2021, https://iddsi.org/IDDSI/media/images/CountrySpecific/UnitedStates/NDD-to-IDDSI-Implementation.pdf (retrieval date - September 25, 2024).).

According to the SafeStraw product website from the product's parent company, Bionix, the company behind the SafeStraw, "The intended use of the Safe Straw is to limit the volume of liquid the patient can draw into his/her mouth in one suck." Two versions of the SafeStraw exist - one to be used for thin fluids and one to be used for nectar-thickened fluids. The product information does not contain any information indicating that the straw is intended to be used in place of thickening a user's fluids (Source: Bionix, SafeStraw drinking aid for thin liquid, no date, https://bionix.com/202.html (retrieval date - September 25, 2024).).

INTERVIEW:

On 09/26/2024, at 3:02 p.m., Surveyor interviewed Licensee K regarding the above concerns related to residents' health monitoring, including the lack of information availability from the designated staff in charge, Caregiver H, regarding Resident 5's eye concerns and Resident 8's rash concerns. Licensee K confirmed understanding Surveyor's concerns and reported that s/he was taking notes to follow up with staff. Licensee K reported s/he did not

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N 431	Continued From page 41 have specific awareness of either situation involving Residents 5, 8, or 9.	N 431		
N 480	83.42(3) Access to resident records. The employee in charge on each work shift shall have a means to access resident records. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure that the employee in charge on each work shift had a means to access resident records. The designated staff left in charge from 09/20/2024 - 10/01/2024, Caregivers H and N, did not have access to portions of each resident's record, including admission agreements, reviewed individual care plans (ISPs), medical reports (which would include treatments, health examinations, and other medical services), or physician orders, including those related to Resident 9's therapeutic diet needs. Findings include: Example 1 - Resident admission agreements, medical reports, and signed ISPs On 09/24/2024, at approximately 7:30 a.m., Surveyor arrived on site to conduct 2 complaint investigations and a verification visit. Caregiver H, who let Surveyor into the building, reported that both staff who were in charge of the facility were on vacation and s/he didn't think s/he could get ahold of them to inform them of Surveyor being on site. Caregiver H reported that the administrator was Administrator L, who had taken	N 480		

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over as the executive director approximately 4 weeks ago. Caregiver H reported that the next person s/he would contact would be Licensee K. At that time, Surveyor interviewed Licensee K via phone call. Licensee K confirmed that Administrator L and Manager M, who would typically be in charge, were both on vacation and would not be back until next week. Licensee K reported that Caregiver H and Caregiver N, who were shift medication passers, were designated in charge while Administrator L and Manager M were on vacation and could work with Surveyor to get requested resident records. After this phone call, Caregiver H confirmed s/he was working first shift but Caregiver N would not be in until second shift.

At approximately 11:00 a.m., Surveyor interviewed Caregiver H regarding resident admission agreements and service charges, the subject of which were related to allegations identified in one of the complaints. Caregiver H reported that s/he did not have access to resident admission agreements and would be unaware of any service charges related to resident cares. Caregiver H reported that some resident records were maintained in residents' paper files, located in the management office. Caregiver H reported that the office was locked and s/he did not have access to it. Caregiver H reported that Administrator L and Manager M, who had access to the office, had left on 09/20/2024 and weren't returning until 10/01/2024. When asked where medical reports for residents, including doctor's visit notes, hospitalization records, and emergency department records, were maintained, Caregiver H reported that that paperwork was typically given to management but s/he was not sure where those records would be located. After the interview, Surveyor observed

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the facility door identified as the office door, which had a sign posted on the front, "Gone on vacation!! We'll be back on October 1st. In case of emergency call: [Licensee K] - [Licensee K phone number]."

At approximately 2:00 p.m., Surveyor interviewed Caregiver H, who had been attempting to obtain requested resident records for Surveyor. Caregiver H confirmed s/he could not find any signed ISPs for residents, including Residents 5, 8, 9, 10, 11, and 12. Caregiver H reported s/he was leaving due to it being the end of his/her shift but Caregiver N (the other caregiver identified by Licensee K as being in charge in the absence of Administrator L and Manager M) was working second shift.

At approximately 3:18 p.m., Surveyor interviewed Caregiver N. Caregiver N reported that s/he did not have access to resident admission agreement or service charge-related information. Caregiver N reported that this information was usually in residents' paper files, located in the management office that s/he did not have access to. Caregiver N reported that medical reports, including doctor's visit notes, hospitalization records, and emergency department records, were typically given to the executive director and s/he thought stored in the residents' paper files. Caregiver N again confirmed s/he did not have access to residents' paper files due to them being stored in the office which was locked.

Example 2 - Physician orders for Resident 9's therapeutic diet

On 09/24/2024, at approximately 9:27 a.m., Surveyor observed Caregiver H administer Resident 9 his/her medications. Resident 9 was

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N 480	Continued From page 44 seated at a table in the dining area finishing breakfast. Surveyor observed a straw in Resident 9's cup, which had a widened lower half. Caregiver H reported that Resident 9 typically required his/her fluids to be thickened, but staff ran out of his/her thickening agent last night and so they were using the straw to help mitigate his/her choking risk. At approximately 12:41 p.m., Surveyor observed Resident 9 finishing lunch. A cup of liquid, consistent in appearance with juice, was in Resident 9's cup and his/her straw was in the cup. Kitchen Staff O confirmed that Resident 9 was served regular juice without thickening agent. Kitchen Staff O reported that Resident 9 using his/her special straw meant there was no need for his/her fluids to be thickened. On 09/24/2024, Surveyor reviewed Resident 9's face sheet from his/her electronic record, which identified that s/he was on a therapeutic diet that consisted of pureed foods and "mildly thick" fluids. A list of orders showed an order for "Thick-it Powder" active as of 01/18/2023 with the instructions, "Use as directed to thicken liquids." At approximately 1:45 p.m., Surveyor interviewed Caregiver H and requested the original medical provider orders for Resident 9's diet. Caregiver H showed Surveyor a document from the provider's electronic record platform, titled "Physician Order Sheet" which showed the same information as Resident 9's face sheet - that s/he was to receive pureed foods and "mildly thick" fluids. There was no evidence of these recommendations having been made by a medical provider or clinician as the document was produced by the provider's electronic record platform and not signed. Caregiver H reported s/he was unable to find any dietary orders in Resident 9's electronic record.	N 480		

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N 480	Continued From page 45 On 09/25/2024, at approximately 11:26 a.m., Surveyor interviewed Patient Representative P, from the clinic of the medical provider documented as having ordered Resident 9's "Thick-it Powder" above. Patient Representative P reported that Resident 9 was no longer an active patient as part of that clinic, as of July 2023, but the last note s/he could see was a communication message from Resident 9's current medical provider on 07/10/2023, which instructed for Resident 9 "to continue nectar thick liquids until re-evaluated by speech therapy."	N 480		