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	0014170	A. BUILDING: _____ B. WING _____	C 10/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM	2671-2673 DURHAM RD GREEN BAY, WI 54311

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N 000	Initial Comments On 10/13/2023, with information gathered thru 10/16/2023, Surveyor conducted a complaint investigation at Durham. Complaint was substantiated. Eight deficiencies were identified. Census: 6	N 000		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview the provider did not report to the department an investigation that concluded alleged abuse, or	N 158		

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

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neglect. The facility did not investigate allegations of neglect within 7 days from the date the community based residential facility should have known about the neglect.

Findings include:

On 10/13/2023 at approximately 11:35 AM, Surveyor requested any investigations of abuse or neglect. Surveyor was handed an investigation dated 06/27/2023. The investigation indicated the following;

Caregiver G reported that staff were not trained well, which led to neglect of residents not getting showers, getting out of bed, and a fresh change of clothes. Caregiver G stated that residents had reported there was a staff member that spoke to them angrily. Caregiver G reported that Former Manager D had witnessed Former Manager D be very impatient with residents and then get agitated and aggressive when residents did not follow his/her speed. Caregiver G stated that Former Manager D would assist Resident 6 who was a 2-person assist and took more time to work with due to pain and muscle spasms. Former Manager D would rush the process which would upset Resident 6.

Caregiver H reported Former Manager D would not come in and assist with the 2-person transfers at night when it was his/her responsibility. Caregiver H reported Resident 6 did not want to transfer with the 2 staff that were on, Former Manager D was called and s/he told Resident 6 that the staff put him/her to bed or s/he would keep him/her in bed for days.

Caregiver I reported there were concerns Former Manager D would do the 2-person assist for

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Resident 6 alone. Caregiver I reported that during one of these times, Former Manager D had hit Resident 6's foot on something and ended up with Resident 6 losing a toe nail. Caregiver I stated residents have reported to him/her that Former Manager D was aggressive and mean. Caregiver I reported s/he had witnessed Former Manager D falsifying charting, charting a resident ate 100% when the meal had not even happened yet. Resident 1 typically wouldn't have bowel movements in his/her briefs, but Former Manager D wouldn't want to transfer Resident 1 to the chair to sit over the toilet, so Former Manager D would tell Resident 6 to just go in their pants. Caregiver I also stated Former Manager D was misappropriating funds. Caregiver I stated there was a time that Former Manager I had went grocery shopping and was gone for 2-3 hours after s/he was supposed to be back, and came back smelling of alcohol.

Resident 2 reported that Former Manager D would yell at residents loudly, and has witnessed Former Manager D yell in front of residents. Resident 2 started crying and stated there was a time when Former Manager D yelled at him/her in front of the other residents and it was embarrassing. Resident 2 also reported Former Manager D would yell at residents.

Resident 6 reported that Former Manager D would yell and swear at him/her. Resident 6 stated that Former Manager D didn't do anything when they were at the facility. Resident 6 also reported Former Manager D would tell him/her s/he was tired of his/her attitude and tell him/her to change it (attitude).

On 10/13/2023, Surveyor reviewed Former Manager D's facility file. Former Manager D had a

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warning notice dated 07/13/2023. The warning stated Former Manager D's demeanor made members feel uncomfortable, "Upon further review it appears [Former Manager D] can become short or frustrated in front of residents if they are not going [his/her] speed or on [his/her] timeline." Staff had reported concerns with not providing adequate training and that Former Manager D was not helping to secure coverage for the 2 person assist. The warning notice showed Former Manager D was demoted on 07/13/2023, to Float Program Lead for the facility. Attached to the warning notice was an Employee Performance Improvement Plan. The plan indicated Former Manager C would practice patience and would ensure staff were trained on their job duties.

On 10/13/2023 at approximately 2:24 PM, Surveyor interviewed Caregiver A. Caregiver A stated Former Manager D was rude to residents. Caregiver A stated Former Manager D had told Resident 6 if s/he wouldn't go to bed s/he would leave him/her in bed for 3 days. Caregiver A stated Former Manager D would refuse to do cares. Caregiver A stated Former Manager D wouldn't give showers for days and wouldn't get Resident 1's Boost. Caregiver A stated this was reported to Former Manager E. Caregiver A stated Former Manager D wouldn't take residents to appointments because s/he didn't like doing transfers. Caregiver A stated Former Manager D would neglect cares with everyone and refuse to do them.

On 10/16/2023 at approximately 1:51 PM, Surveyor interviewed Case Manager F. Case Manager F stated there were a lot of missed appointments from February 2023 until June/July of 2023. Case Manager F stated there were

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speech therapy appointments missed, medical appointments that were being missed and missing documentation for weights and food intake. Case Manager F stated there were several conversations with Former Manager D regarding the missing appointments, missing food logs, and weights not being completed as ordered. Case Manager F stated when they would speak to Former Manager D regarding these concerns s/he would just brush the concerns off. Case Manager F stated Resident 1 was supposed to have a speech board in January 2023, but still had not received the board. Case Manager F stated Former Manager D would not report accurate weights when s/he would report the weights to them. Case Manager F stated s/he had tried reaching out to Former Manager E over 20 times leaving messages and s/he would not respond to his/her calls or messages. Case Manager F also stated s/he could never get copies of after visit summaries even when visiting the facility they wouldn't have copies of the medical visits. Case Manager F stated this all occurred from February 2023 until June/July of 2023.

Summary

Former Manager D was neglecting resident cares and yelling at residents. Former Manager D threatened a resident that if s/he did not go to bed, s/he would be left in bed for three days. Former Manager E had several messages left by care team and reports from staff that Former Manager D was not completing job duties or helping with residents' personal cares and was not responding to the messages or the reports that started in February 2023. The only investigation that was produced at the time of survey was for Former Manager D who was

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N 158	Continued From page 5 neglecting resident cares, not following physician orders for weights and intake logs, not ensuring supplements were at the facility for Resident 1, and yelling at residents.	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 review and interview the provider did not investigate an injury that was not observed by any person, could not be adequately explained by Resident 1, or that appeared suspicious because of the location of the injury. Findings include: On 10/13/2023, at approximately 12:05 PM, Surveyor reviewed Resident 1's facility file. -On 04/02/2023, A document named "incident report": stated Resident 1 was having a brief changed and it was discovered a fair amount of blood was on the brief. Resident 1 stated s/he was in pain and needed to go to the hospital. An ambulance was summoned and Resident 1 was taken to the emergency room for further evaluation. The incident classification of the report is "injury -unknown source".	N 161		

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N 161	Continued From page 6 On 10/13/2023, Surveyor requested additional information regarding the above incident to include medical documentation and an investigation for an injury of unknown orgin. On 10/13/2023 at approximately 1:11 PM, Case Manager C stated there probably wasn't a self-report or investigation for the injury of unknown orgin. Case Manager C stated s/he would look for documentation but could not find any documentation of the above incident. On 10/16/2023, Surveyor reviewed the departments facility file. There was no documentation of an injury of unknown orgin sent to the department to review.	N 161		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview the provider did not send a written report to the department within 3 working days after incidents which resulted in serious injury requiring hospital admission or emergency room treatment of a resident. Findings include: On 10/13/2023, at approximately 12:05 PM,	N 165		

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N 165	Continued From page 7 Surveyor reviewed Resident 1's facility file. -On 04/02/2023, A document named "incident report": stated Resident 1 was having a brief changed and it was discovered a fair amount of blood was on the brief. Resident 1 stated s/he was in pain and needed to go to the hospital. An ambulance was summoned and Resident 1 was taken to the emergency room for further evaluation. The incident classification of the report is "injury -unknown source". -On 08/22/2023, A document named "incident report" stated Resident 1 was in the bathroom and had asked staff to leave the bathroom for privacy, when staff returned Resident 1 was on the floor on his/her back. Resident 1 stated s/he was in pain. Ambulance was called and sent to the emergency room. The document also indicated Resident 1 was admitted into the hospital. -On 10/01/2023, a document named "incident report" stated Resident 1 was taken to the emergency room because there was no urine output inside the urine bag. Resident was transferred to the emergency room where Resident 1's catheter was changed because it was not in place. On 10/13/2023 at approximately 1:11 PM, Surveyor interviewed Care Manager C. Care Manger C stated the incidents were probably not reported by the previous manager. Care Manager C stated s/he would look for the appointment papers but stated s/he didn't think they had them. On 10/16/2023, Surveyor reviewed the department's facility e-file. There were no self-reports documented from 2022 or 2023.	N 165		

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N 346	83.32(3)(b) Rights of Residents: Confidentiality In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Confidentiality. Confidentiality of health and personal information and records, and the right to approve or refuse release of that information to any individual outside the CBRF, except when the resident is transferred to another facility or as required by law or third-party payment contracts and except as provided in s.146.82(2) and (3), Stats. The CBRF shall make the record available to the resident or the resident ' s legal representative for review. Copies of the record shall be made available within 30 days, if requested in writing, at a cost no greater than the cost of reproduction. This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure the confidentiality for 4 of 6 residents residing at the facility was protected when personal information was posted on doors at the facility. Findings include: On 10/13/2023 at approximately 11:40 AM, Surveyor observed papers taped on the outside of 4 residents' doors at the facility. -A note titled, "Reminder for Thursdays" was posted on Resident 2's door and stated, "Please make sure to pass alendronate medications at 7 AM every Thursday morning with an 8 ounce glass of water. No breakfast for 1 hour after [s/he] has taken the medication."	N 346		

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N 346	Continued From page 9 -A note titled, "[Resident 3's] cheat sheet" was posted on Resident 3's door and stated, "S/he may have to be waken to give meds," gave Resident 3's preferred name, stated Resident 3 was independent with showers, s/he was lactose intolerant with special meals, had 11 AM medications, had no teeth and needed foods prepared for him/her. -A note titled, "[Resident 4's] cheat sheet" was posted on Resident 4's door and detailed information about his/her 7 am showers, what s/he liked for lunch, that s/he used special utensils and plates for meals, needed assistance being pushed up to the table, if bowel movement happened that s/he will take self to bathroom and ring when done, 8 PM meds were taken with yogurt, stated s/he would put self to bed, and needed a towel for support under lower back and 1 under legs. -A note titled, "[Resident 5's] cheat sheet" and posted on Resident 5's door stated Resident 5 was on full assist with all cares, was a two person assist for transfers, had sensitive feet, gets up around 11:00 AM and does not eat breakfast, would ask to use the urinal a few times before getting up, received a bed bath on days s/he didn't get a shower, gave a detailed description on how to get him/her up, that s/he ate independently, could stay in bed if only 1 staff on, s/he needed a snack offered 1-2 hours after meals, had 8 PM medications, and gave a detailed description of his/her bedtime routine. -A note titled, "Durham House Times for Passing Medication" posted in a common area gave the times and medications that were to be passed to all residents and when. The posting also	N 346		

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N 346	Continued From page 10 described how the medications were to be taken. -A note titled, "[Resident 5] 2nd shift" and posted on Resident 5's door stated, "[Resident 5] comes home at 3-4 PM, sometimes wants a snack, after dinner [his/her] shower should be done, may need verbal cues, help washing hair and body, has prescribed acne wash, and has prescribed foot cream. Has 8 PM medications, will have some behavior motives that should be looked out for drink stealing, drink pouring, and door slamming. ..." The posting also indicated Resident 5 was non-verbal and his/her shower was to be taken on 2nd shift. On 10/13/2023 at approximately 1:54 PM, Surveyor interviewed Manager B. Manager B stated s/he put the postings up on the door as cheat sheets to help caregivers know what needed to be done because they had newer caregivers. Manager B stated s/he would take them down right away.	N 346		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure Resident 1 received all prescribed medications in the dosage and at the intervals prescribed by a practitioner.	N 352		

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N 352	Continued From page 11 Findings include: Resident 1 had dianoses of nutritional deficiency, cerebral paulsy, and abnormal weight loss. On 10/13/2023 at approximately 11:05 AM, Surveyor reviewed Resident 1's medication administration records. The following was reviewed: June 2023 Resident 1's medication administration record documented 13 times medications were not at the facility and needed to be reordered. The medication administration record indicated the medications that were not given were Poly glycol 3350 powder, Boost energy drink, and diazepam 5mg. The medication orders were as follows: Diazepam 5 MG tablet 1 tablet by mouth every 8 hours for muscle spasms/seizures. Order dated 06/15/2023, no discontinue order. Boost energy drink 2 times daily for caloric supplement. Order dated 05/26/2022, no discontinue order. Poly glycol 3350 powder dissolve 17 MG in liquid and drink by mouth once daily. Order dated 03/31/2022, no discontinue order. May 2023 Resident 1's medication administration record indicated 1 time Diazepam 5MG tablet was not at the facility and not in the bubble pack.	N 352		

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N 352	Continued From page 12 Diazepam 5 MG tablet, 1 tablet by mouth every 8 hours for muscle spasms/seizures. Order dated 05/10/2023, no discontinue order. On 10/13/2023 at approximately 1:54 PM, Surveyor shared findings with Manager B. Manager B stated s/he was on the way to get boost because the facility had ran out a couple of days ago. Manager B stated that s/he was not working at the facility prior to July and wasn't sure what had happened prior to him/her coming on board as a manager. On 10/13/2023 at approximately 2:24 PM, Surveyor interviewed Caregiver A. Caregiver A stated a previous manager was in charge of getting the boost and the facility would often run out because they wouldn't go pick it up.	N 352		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan.	N 387		

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N 387	Continued From page 13 This Rule is not met as evidenced by: Based on record review and interview the provider did not have Resident 1 or Resident 1's care team sign the individual service plan acknowledging their involvment in, understanding of, and agreement with the plan. Findings include: On 10/13/2023 at approximately 11:05 AM, Surveyor reviewed Resident 1's faciltiy file. Resident 1's individual service plan was dated 10/03/2023, but did not have required signatures. On 10/13/2023 at approximately 1:39 PM, Surveyor shared findings with Care Manager C. Care Manager C stated the last signed individual service plan was dated 06/16/2022, and the facility did not have a signed care plan since then.	N 387		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.	N 415		

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N 415	Continued From page 14	N 415		

This Rule is not met as evidenced by:
Based on record review and interview the provider did not ensure documentation of medication administration for Resident 1. The provider did not ensure the person administering the medication documented the dosage, date and time of medication taken in the medication administration record.

Findings include:

On 10/13/2023 at approximately 11:05 AM, Surveyor reviewed Resident 1's facility file.

Surveyor reviewed Resident 1's medication administration records from March 2023 through July 2023.

March 2023

Resident 1's medication administration record from March 2023 documented 33 instances where medications were not signed off as given. The medications that were not signed off on include tamsulosin, olopatadine, mirtazapine, sertraline, doc sod, trihexyphen, calcuim citrate, senna, dicyclomine, poly glycol, cetirizine, omeprazole, topiramate, diazepam, and boost energy.

May 2023

Resident 1's medication administration record from May of 2023 documented on 05/10/2023, diazepam was refused by Resident 1 but the comments stated the medication wasn't available at the facility.

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N 415	Continued From page 15 June 2023 Resident 1's medication administration record indicated on 06/02/2023, 06/06/2023, 06/07/2023 poly glycol 3350 powder was not available at the facility. 06/20/2023 through 06/23/2023 indicated Resident 1 did not receive Boost energy drink because it was not at the facility. July 2023 Resident 1's medication administration record indicated 16 instances where medications were not documented as given. The following medications were not documented as given: tamsulosin, mirtazapine, sertraline, docusate, calcium citrate, diazepam, and boost energy drink. On 10/13/2023 at approximately 1:54 PM, Surveyor shared findings with Manager B. Manager B stated s/he was on the way to get Boost because the facility had ran out a couple of days ago. Manager B stated that s/he was not working at the facility prior to July and wasn't sure what had happened prior to him/her coming on board as a manager. On 10/13/2023 at approximately 2:24 PM, Surveyor interviewed Caregiver A. Caregiver A stated a previous manager was in charge of getting the Boost and the facility would often run out because they wouldn't go pick it up. Cross Reference: 83.32(3)(h) Rights of Residents: Received Medication	N 415		

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N 431	Continued From page 16	N 431		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview the provider did not monitor the health of Resident 1.	N 431		

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N 431	Continued From page 17 The provider did not make arrangements for physical health and mental health services. The provider did not observe Resident 1's food and fluid intake, monitor weight changes, and did not document appointments in Resident 1's facility file. Findings include: Resident 1 had diagnoses of cerebral palsy, nutritional deficiency, and abnormal weight loss. On 10/13/2023 at approximately 11:05 AM, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 09/30/2018. Resident 1 had orders dated 12/2022 to have weekly weight checks completed. The medical order also stated to monitor meal intake because of nutritional deficiency and abnormal weight loss Surveyor reviewed Resident 1's vital history since 01/01/2023. -Resident 1 had weight taken on 03/01/2023, 03/02/2023, 03/29/2023,03/30/2023, 06/09/2023, 08/18/2023, and 09/29/2023. Resident 1's weights ranged from 67.902 pounds to 94 pounds. Resident 1 was to have meal intake monitored because of nutritional deficiency and abnormal weight loss. Surveyor reviewed Resident 1's food intake log from 04/01/2023 through 06/30/2023. -During the time Period of 04/01/2023 thru 06/30/2023, there were 90 meal intake logs missing from the documentation. All meals were not recorded of what Resident 1's food intake was. Resident 1's individual service plan dated	N 431		

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N 431	Continued From page 18 06/27/2023, stated Resident 1 was to receive weekly weights on Fridays. The individual service plan also indicated the weights were to be emailed to Resident 1's care team. Resident 1's individual service plan indicated Resident 1 was to be monitored for food intake. Resident 1's individual service plan dated 10/03/2023, stated Resident 1 was to receive weekly weights on Wednesdays and it was to be documented in Resident 1's file. Resident 1's individual service plan indicated weekly weights were to be sent to his/her care team weekly. Resident 1's individual service plan indicated due to low weight staff were to monitor how much food Resident 1 ate at lunch and supper. Resident 1 did not have any medical documentation for after visits of medical appointments. On 10/13/2023 at approximately 12:10 PM, Surveyor interviewed Case Manager C. Case Manager C stated Former Manager D used to be the house manager at the facility. Case Manager C stated Resident 1 was not getting weighed for quite a while and was supposed to be weighed weekly. Case Manager C stated there were issues with Former Manager D but the facility was working on getting things back on track. Case Manager C stated the facility did not have paper copies of medical visits for the after summary, and that s/he stated s/he would look but stated s/he doubted they were there. On 10/13/2023 at approximately 11:42 AM, Surveyor interviewed Caregiver A. Caregiver A stated Resident 1 had missed appointments. Caregiver A stated Resident 1 had actually been in the hospital quite a bit because they had issues	N 431		

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N 431	Continued From page 19 with the indwelling catheter. On 10/13/2023 at approximately 2:35 PM, Care Manager C stated there were orders for weights and intake/output monitoring, but could not find the orders in the facility file for Resident 1. Care Manager C stated s/he had received that information from Resident 1's Care team. On 10/16/2023 at approximately 1:51 PM, Surveyor interviewed Case Manager F. Case Manager F confirmed there were numerous missed appointments for Resident 1. Case Manager F confirmed the following dates appointments were missed: 08/09/2022, Resident 1 had an appointment to have a cystoscopy that was canceled. 08/11/2022, Resident 1 had a urology appointment that was canceled. 10/31/2022, Resident 1 had an appointment for urology that was canceled. 11/11/2022, Resident 1 had an appointment to discuss litholink for kidney stone prevention, the appointment was canceled. 12/01/2022, Resident 1 had an appointment with urology and it was canceled and rescheduled for 12/08/2022. 12/08/2022, Resident 1 had an appointment for urology and it was a no show. 12/13/2022, 12/14/2022, and 12/15/2022 Resident 1 was treated in the emergency room for fever, hematuria blood in urine and was instructed to follow up with urology. Resident 1 had 2 emergency room visits in August of 2022 (per Case Manager F exact dates could not be located).. Resident 1 had the following emergency room	N 431		

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N 431	Continued From page 20 visits in 2023 per resident record; 01/06/2023- urinary complaints/pain 01/07/2022- dizziness and urinary symptoms 03/26/2023- pain unspecified 04/02/2023- acute cystitis with hematuria 04/05/2023- urogenital implants 04/14/2023- nausea 05/25/2023- infection and inflammation due to indwelling catheter UTI 06/07/2023- Sepsis inpatient for 3 days due to indwelling catheter 06/24/2023- GI symptoms On 10/16/2023 at approximately 2:00 PM, Case Manager F confirmed since 01/2023, Resident 1 was supposed to have speech therapy appointments to get a voice board for communicating. Case Manager F stated as of now Resident 1 still didn't have a voice board and a lot of appointments were missed for speech therapy. Case Manager F stated the voice board was supposed to arrive 10/31/2023. Case Manager F stated the facility was supposed to be sending weekly weights to the case management team and also food intake logs every two weeks and the facility was not sending the documentation. Case Manager F stated since the new manager took over things were starting to turn around, but Former Manager D was notified numerous times of concerns and would not take the concerns seriously. Case Manager F stated the care team had also attempted to reach out to Former Manager E numerous times leaving messages and would never receive a call back. Case Manager F stated the order for intake logs was supposed to be for every meal that was eaten including breakfast, lunch, and supper. Summary	N 431		

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N 431	Continued From page 21 Resident 1 had multiple missed appointments which resulted in numerous emergency room visits. Resident 1 was not weighed weekly as ordered. Resident 1's food intake was not monitored as ordered. Resident 1 did not receive speech therapy in a timely manner which resulted in Resident 1 not receiving a voice board to aid in communication. Cross Reference N0158 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0352 83.32(3)(h) Rights of Residents: Receive Medication	N 431		