STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015199	A. BUILDING: _____ B. WING _____	C 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE SUN PRAIRIE	LIGHTHOUSE OF SUN PRAIRIE SUN PRAIRIE, WI 53590

(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 10/11/2023, with information obtained through 10/12/2023, the Bureau of Assisted Living, Southern Regional Office, conducted two complaint investigations at New Perspective Sun Prairie, a community-based residential facility (CBRF) located in Sun Prairie, WI. As a result of the survey, 6 deficiencies were identified. Two deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) 9PKX12, dated 09/05/2023, and SOD LHXR11, dated 08/30/2022. One complaint was substantiated, one complaint was unsubstantiated. Census: 32	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	N 158		

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

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N 158	Continued From page 1 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 investigate and document the allegation of a caregiver stealing Resident 2's phone and using 39 gigs of data. The provider did not conclude whether the allegation med the definition of misappropriation of property. Findings include: On 09/08/2023, the Department received a complaint alleging that Resident 2 was not properly taken care of and that his/her cell phone was stolen. On 10/11/2023, Surveyors conducted 2 complaint investigations. The provider is licensed as a class CNA (non-ambulatory) CBRF able to serve up to 50 residents within the client groups of advanced aged and irreversible dementia/Alzheimer's. Surveyor asked Administrator A to review any allegations of misappropriation. At approximately 4:30 p.m., Administrator A provided Surveyor with an email sent from Administrator A to members of the provider's human resources team. The email was dated 8/15/2023 at 2:12 p.m. and stated, "Last week on Thursday I had a care conference with [Resident 2]'s family. [Resident 2] is a resident in our memory care and [his/her] family had bought [him/her] and iPhone 7 so that [s/he] could communicate with them and control some of the devices within [his/her] apartment. The	N 158		

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N 158	Continued From page 2	N 158		

family noticed recently that [Resident 2's] data usage shot up like crazy in June and July and when they looked into it more, it showed that [his/her] phone was being used as a wifi hotspot during those months. They also found that there was a stranger's airpods connected to [Resident 2's] phone with the name "Jazya AirPods #2"

Now we don't have any team members with that name, but we do employ a [Caregiver G] and [his/her family member] [Caregiver H]. [Caregiver G] has been seen on many occasions working in memory care with airpods in and we have heard from other caregivers that [s/he] sometimes refers to [his/her family member] as Jazya. I tried checking time sheets but the data usage they showed us doesn't give specific dates/times but we have a gut feeling that one or both of these team members are involved with misappropriating the phone and data."

Administrator A sent a follow-up email dated 08/16/2023 at 12:39 p.m., "I would have to submit this report to the state potentially tomorrow to be in compliance with their reporting guidelines. Do you think we have enough to suspend [Caregiver G] and [Caregiver H] pending the results of the investigation?"

At 5:37 p.m., Surveyor asked Administrator A what steps were taken to ensure the safety of the residents after the allegation of misappropriation was made. Administrator A stated that when the provider started the investigation, both caregivers resigned. Surveyor asked to review the documentation of the investigation and asked what the conclusion of the investigation was. Administrator A stated that Caregiver G and Caregiver H resigned and that when Resident 2's POA was asked for a written statement, s/he

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N 158	Continued From page 3 wanted to reverse his/her statement because s/he did not believe it could have been Caregiver G. Surveyor asked for that documentation and the conclusion of the investigation. Administrator A stated that Corporate said they did not have enough to prove misappropriation and that the provider instructs resident's to get renter's insurance, and that it is a police matter. Administrator A was unable to provide documentation of the allegation of the misappropriation of Resident 2's cell phone and data plan, that an investigation was conducted, and the conclusion of that investigation.	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 ensure that injuries sustained on 2 different occurrences by Resident 1 which were not observed and could not be explained by him/her were investigated. Resident 1 sustained an upper extremity skin tear around 08/28/2023 (exact date unknown) and again on 10/08/2023. Both were unwitnessed by staff until after the injuries were already sustained. Resident 1 reported not being sure	N 161		

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N 161	Continued From page 4	N 161		

when or how the first injury occurred but had reported a fall as well. For the second injury, staff documented, "Tried to shower on [his/her] own and fell. Has a skin tear," with nothing further documented about the skin tear.

Findings include:

On 10/11/2023, at approximately 3:00 p.m., Surveyor interviewed Family Member E, who was the activated power of attorney for healthcare (POA) for Resident 1. Family Member E reported s/he wished communication between staff and residents' families was better. When Surveyor asked for further clarification, Family Member E explained that on Monday when s/he went to go visit Resident 1, s/he saw a bandage on his/her arm but did not know why that was there. Family Member E reported that later that day s/he found out from caregiving staff that on 10/08/2023 (the previous day), Resident 1 attempted to shower him/herself, fell, and experienced a skin tear.

On 10/11/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 05/31/2023 with diagnoses including Alzheimer's disease. Resident 1's record confirmed that Family Member E was his/her activated POA. Resident 1's comprehensive assessment, dated 06/05/2023 indicated that Resident 1's cognitive status required him/her to live in the provider's memory care setting, that s/he was only oriented to person, and that s/he experienced forgetfulness. Surveyor reviewed Resident 1's progress notes from his/her admission through the current day. An entry by Nurse B on 08/28/2023 documented, "Writer was called to resident's room. [S/he] had taken a fall unsure of what day. There are no written reports from staff. [S/he] has a large skin tear to [his/her]

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left arm. Steri strips, non-adherent pad and kling applied. States [s/he] fell in [his/her] room but doesn't know what day. POA was notified. Will continue to follow up with staff." There was no entry or information about his/her fall and resulting skin tear on 10/08/2023. At approximately 4:00 p.m., Surveyor requested any and all incident or fall reports for Resident 1, to which Administrator A replied that s/he had none.

At approximately 4:35 p.m., Surveyor interviewed Nurse B. Nurse B reported that Resident 1 has experienced a couple of skin tears. Regarding the first documented skin tear around 08/28/2023, Nurse B reported s/he didn't know the exact date the tear was sustained but it was first seen by caregiving staff on 08/28/2023 when they were showering Resident 1. Nurse B reported that the tear was still actively bleeding when observed by staff but "not much." Nurse B reported that s/he asked Resident 1 about the tear and s/he replied that s/he wasn't sure what happened. Nurse B reported that staff thought the tear came from a fall but reported s/he personally did not observe blood anywhere else in Resident 1's room. Nurse B reported that staff would normally assess a resident post-fall by completing an incident report, but none was completed for that incident. Regarding Resident 1's most recent skin tear, sustained on 10/08/2023, Nurse B reported that the tear occurred on Resident 1's left arm but that it wasn't brought to his/her attention until Monday, 10/09/2023. Surveyor asked if there was any documented information about this skin tear.

Surveyor then reviewed a "24-Hour Shift Log" document, provided by Nurse B at approximately 4:50 p.m.. The report had an entry for Resident 1, which documented, "Tried to shower on [his/her] own and fell. Has a skin tear." Nothing further

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N 161	Continued From page 6 was documented. At that time, Nurse B confirmed s/he did not have any additional information about the 2 skin tears or that s/he had evidence of investigations being completed for both skin tears. At approximately 5:17 p.m., Surveyor interviewed Administrator A. Administrator A reported s/he was unaware of Resident 1's skin tears. Administrator A acknowledged Surveyor's concern that the skin tears experienced by Resident 1 around 08/28/2023 and 10/08/2023, were not investigated.	N 161		
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 the Resident 1's legal representative was notified when Resident 1 experienced an injury on 10/08/2023. Resident 1 experienced a left arm skin tear, which was observed by staff on 10/08/2023. Family Member E, who was Resident 1's legal representative (activated power of attorney for healthcare (POA)), was not notified of the injury	N 169		

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and only discovered it when s/he personally observed a bandage on Resident 1's arm upon visiting him/her a day later on 10/09/2023.

Findings include:

On 10/11/2023, Surveyors conducted a complaint investigation into concerns of adequate communication between staff and family members upon residents experiencing changes of condition.

On 10/11/2023, at approximately 3:00 p.m., Surveyor interviewed Family Member E, who was the activated power of attorney for healthcare (POA) for Resident 1. Family Member E reported s/he wished communication between staff and residents' families was better. When Surveyor asked for further clarification, Family Member E explained that on Monday when s/he went to go visit Resident 1, s/he saw a bandage on his/her arm but did not know why that was there. Family Member E reported that later that day s/he found out from caregiving staff that on 10/08/2023 (the previous day), Resident 1 attempted to shower him/herself, fell, and experienced a skin tear. Family Member E confirmed that no one contacted her prior to this to inform him/her of Resident 1's skin tear.

On 10/11/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 05/31/2023 with diagnoses including Alzheimer's disease. Resident 1's record confirmed that Family Member E was his/her activated POA. Surveyor reviewed Resident 1's progress notes from his/her admission through the current day. There was no entry or information about his/her fall and resulting skin tear on 10/08/2023.

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N 169	Continued From page 8 At approximately 4:35 p.m., Surveyor interviewed Nurse B. Nurse B reported that Resident 1's skin tear occurred on his/her left arm but that it wasn't brought to his/her attention until Monday, 10/09/2023. Surveyor asked if there was any documented information about this skin tear. Surveyor then reviewed a "24-Hour Shift Log" document, provided by Nurse B at approximately 4:50 p.m.. The report had an entry for Resident 1, which documented that on the day shift Resident 1, "Tried to shower on [his/her] own and fell. Has a skin tear." Nothing further was documented. Upon interview at that time, Nurse B reported that s/he didn't think staff informed Family Member E of Resident 1's skin tear. Nurse B reported that caregiving staff would have been expected to call the on-call nurse upon discovering Resident 1's skin tear, and that the on-call nurse would then call Resident 1's POA, but since nursing staff weren't aware of the injury until 10/09/2023 (the day after it was sustained), Resident 1's POA would likely not have been notified. At approximately 5:17 p.m., Surveyor interviewed Administrator A. Administrator A reported s/he was unaware of Resident 1's skin tear. Administrator A acknowledged Surveyor's concern that Resident 1's POA, Family Member E, was not immediately notified when s/he experienced the skin tear on 10/08/2023.	N 169		
N 362	83.33(1)(d) Grievance procedure: written summary The CBRF shall provide a written summary of the grievance, the findings and the conclusions and any action taken to the resident or the resident ' s	N 362		

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N 362	Continued From page 9 legal representative and the resident ' s case manager. The CBRF shall maintain a copy of the investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide a written summary of the grievance, the findings and the conclusion to grievances Resident 2's guardian had with Resident 2's care. Findings include: On 09/08/2023, the Department received a complaint alleging that Resident 2 was not properly taken care of and that his/her cell phone was stolen. On 10/11/2023, Surveyors conducted 2 complaint investigations. The provider is licensed as a class CNA (non-ambulatory) CBRF able to serve up to 50 residents within the client groups of advanced aged and irreversible dementia/Alzheimer's. Surveyor asked Administrator A to review any grievances that had been filed in the last 3 months. At approximately 2:20 p.m., Administrator A provided Surveyor with a correspondence between Resident 2's power of attorney (POA) and RN F, where the POA goes into detail with concerns regarding dirty clothing, resident supervision, wandering, hand hygiene, staff demeanor, sleep hygiene, food safety, caregivers bringing children into the facility, trainings, staff accountability and a police report regarding Resident 2's missing cell phone.	N 362		

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N 362	Continued From page 10 At 4:07 p.m., Surveyor asked if Administrator A provided Resident 2's POA with a written summary of the grievance findings, conclusions and any actions taken. Administrator A stated, no, not in writing. At approximately 5:30 p.m., Surveyors reviewed the concerns with Administrator A. Administrator A stated that s/he might have correspondence between him/herself and Resident 2's POA regarding their concerns. Surveyor asked Administrator A to provide any documentation of the findings, conclusion and action taken that was provided to Resident 2's POA in writing by 10/12/2023 at 4:00 p.m. On 10/12/2023, at 3:32 p.m., Administrator A emailed Surveyor a screen shot of a text message between Administrator A and Resident 2's POA, dated 08/07/2023, where Resident 2's POA provides Administrator A with information regarding the screen name of the person's whose AirPods are connected to Resident 2's iPhone and stated that this caregiver has used 39 gigs of data. Administrator A responded stated that they do not have any team members with that name so s/he was unsure of who that would be but that s/he would speak with another team member right away. At 4:05 p.m., Surveyor emailed Administrator A stating, "Yes, you had written/text contact with the POA, but the grievance concerns, findings and conclusion, and actions taken were not documented and provided to the resident's POA and case manager. Most of the issues were not addressed in the text."	N 362		

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N 389	Continued From page 11	N 389		
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 and interview, the provider did not ensure that Resident 1's individual service plan (ISP) was updated to reflect the change in his/her fall prevention needs. Resident 1 was thought to have experienced a fall around 08/28/2023 and was documented as having a fall on 10/08/2023. Both resulted in upper extremity skin tears, with one being documented as a "large skin tear." There was no updated information in his/her ISP regarding fall prevention or fall risk mitigation interventions upon Resident 1 experiencing these falls. Findings include: On 10/11/2023, at approximately 3:00 p.m., Surveyor interviewed Family Member E, who was the activated power of attorney for healthcare (POA) for Resident 1. Family Member E reported	N 389		

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s/he wished communication between staff and residents' families was better. Family Member E explained that on Monday when s/he went to go visit Resident 1, s/he saw a bandage on his/her arm but did not know why that was there. Family Member E reported that later that day s/he found out from caregiving staff that on 10/08/2023 (the previous day), Resident 1 attempted to shower him/herself, fell, and experienced a skin tear. Family Member E reported that Resident 1 is known to experience falls, often stemming from him/her attempting to do cares by him/herself.

On 10/11/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 05/31/2023 with diagnoses including Alzheimer's disease. Resident 1's record confirmed that Family Member E was his/her activated POA. Resident 1's comprehensive assessment, dated 06/05/2023 documented that Resident 1 was not able to use a pendant. There was no information in his/her comprehensive assessment about his/her fall risk. Resident 1's current ISP, dated 05/30/2023 (day prior to admission), documented the following under the "Falls Management" section:

"Resident is at risk for falls. Encourage resident to wear properly fitting foot ware[sic] or non-slip socks; keep walkways within apartment free of clutter; participate in community exercise activities to support physical endurance and strength; keep call pendant, if in use, within reach; place pull cord, if available, within reach when in their bedroom; and drink fluids in-between meals and at mealtime. Promptly report to nursing any changes in cognitive status, such as confusion, increased confusion from baseline, or impulsiveness; symptoms of [urinary tract infection] including, but not limited to

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE SUN PRAIRIE	LIGHTHOUSE OF SUN PRAIRIE SUN PRAIRIE, WI 53590

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N 389	Continued From page 13	N 389		

frequency (feeling the urge to urinate), burning with urination, foul smelling urine; or changes in mobility such as changes in gait or unsafe-self transfers."

Surveyor reviewed Resident 1's progress notes from his/her admission through the current day, and observed the following:

- Entry on 06/27/2023 by Nurse F: "Received updated therapy report from [therapy company] for resident. [S/he] demonstrated decreased safety awareness when performing functional mobility by sitting down uncontrollably onto surfaces and abandoning walker in [his/her] room..."

-Entry on 08/28/2023 by Nurse B: "Writer was called to resident's room. [S/he] had taken a fall unsure of what day. There are no written reports from staff. [S/he] has a large skin tear to [his/her] left arm. Steri strips, non-adherent pad and kling applied. States [s/he] fell in [his/her] room but doesn't know what day. POA was notified. Will continue to follow up with staff."

There was no entry or information about his/her fall and resulting skin tear on 10/08/2023.

At approximately 4:00 p.m., Surveyor requested any and all incident or fall reports for Resident 1, to which Administrator A replied that s/he had none.

At approximately 4:35 p.m., Surveyor interviewed Nurse B. Surveyor asked about Resident 1's skin tear sustained around 08/28/2023. Nurse B reported that s/he asked Resident 1 about the tear and s/he replied that s/he wasn't sure what happened. Nurse B reported that staff thought the

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N 389	Continued From page 14 tear came from a fall. Surveyor asked if staff implemented any new fall prevention / fall risk mitigation strategies after Resident 1 had experienced the 2 most recent documented falls. Nurse B reported that staff reminded Resident 1 to use his/her call light and that they were doing "more frequent checks." Surveyor asked if there were any specific time parameters for how much more frequent these checks were to be completed. Nurse B replied there were none. At approximately 5:17 p.m., Surveyor interviewed Administrator A. Administrator A acknowledged Surveyor's concern that reminding Resident 1 to use his/her call light didn't seem to be an effective fall prevention intervention given that his/her own comprehensive assessment documented s/he was not able to use a pendant. Administrator A acknowledged Surveyor's concern that there was no updated information in Resident 1's ISP regarding updated fall prevention interventions given Resident 1's recent history of 2 falls, one of which had a resulting skin injury and the other of which was thought to be related to a separate skin injury.	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.	N 431		

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N 431	Continued From page 15 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 ensure that Resident 1's health was monitored after s/he reported experiencing a fall around 08/28/2023, experienced a "large skin tear" around that same day, and experienced a fall on 10/08/2023 with a resulting skin tear. This is a repeat deficiency. See Statement of Deficiency (SOD) LHXR11, dated 08/30/2022. Findings include: On 10/11/2023, at approximately 3:00 p.m., Surveyor interviewed Family Member E, who was the activated power of attorney for healthcare	N 431		

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(POA) for Resident 1. Family Member E reported s/he wished communication between staff and residents' families was better. When Surveyor asked for further clarification, Family Member E explained that on Monday when s/he went to go visit Resident 1, s/he saw a bandage on his/her arm but did not know why that was there. Family Member E reported that later that day s/he found out from caregiving staff that on 10/08/2023 (the previous day), Resident 1 attempted to shower him/herself, fell, and experienced a skin tear. Family Member E reported concerns that when Resident 1 requires bandages that staff are not changing them with adequate frequency. Family Member E clarified that Resident 1 in the past had experienced an upper extremity skin tear which was managed with a bandage covering. Family Member E reported that sometime after that incident another family member had visited Resident 1 and reported that his/her upper extremity (near the bandage) was foul-smelling and that s/he didn't think staff had changed the bandage in a while. Family Member E reported s/he discussed this with staff and that after that, Resident 1's bandage was changed.

On 10/11/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 05/31/2023 with diagnoses including Alzheimer's disease. Resident 1's record confirmed that Family Member E was his/her activated POA. Resident 1's comprehensive assessment, dated 06/05/2023 indicated that Resident 1's cognitive status required him/her to live in the provider's memory care setting, that s/he was only oriented to person, and that s/he experienced forgetfulness.

Surveyor reviewed Resident 1's progress notes from his/her admission through the current day.

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An entry by Nurse B on 08/28/2023 documented, "Writer was called to resident's room. [S/he] had taken a fall unsure of what day. There are no written reports from staff. [S/he] has a large skin tear to [his/her] left arm. Steri strips, non-adherent pad and cling applied. States [s/he] fell in [his/her] room but doesn't know what day. POA was notified. Will continue to follow up with staff." There was no entry or information about his/her fall and resulting skin tear on 10/08/2023. At approximately 4:00 p.m., Surveyor requested any and all incident or fall reports for Resident 1, to which Administrator A replied that s/he had none.

At approximately 4:35 p.m., Surveyor interviewed Nurse B. Regarding the first documented skin tear around 08/28/2023, Nurse B reported s/he didn't know the exact date the tear was sustained but it was first seen by caregiving staff on 08/28/2023 when they were showering Resident 1. Nurse B reported that the tear was still actively bleeding when observed by staff but "not much." Nurse B reported that s/he asked Resident 1 about the tear and s/he replied that s/he wasn't sure what happened. Nurse B reported that staff thought the tear came from a fall but reported s/he personally did not observe blood anywhere else in Resident 1's room. Surveyor asked if additional information about the skin tear was documented or if staff assessed Resident 1 for any injuries after his/her report of falling. Nurse B reported that staff would normally assess a resident post-fall by completing an incident report, but none was completed for that incident. Nurse B confirmed s/he had no other information about Resident 1's skin tear from that incident. Surveyor asked how staff were to know to care for Resident 1's skin tear or complete bandage changes. Nurse B reported that staff would've

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been expected to change Resident 1's bandage every 3 days. Nurse B reported this expectation wasn't documented anywhere but that staff would have just known to do it. Regarding Resident 1's most recent skin tear, sustained on 10/08/2023, Nurse B reported that the tear occurred on Resident 1's left arm but that it wasn't brought to his/her attention until Monday, 10/09/2023. Surveyor asked if there was any documented information about this skin tear.

Surveyor then reviewed a "24-Hour Shift Log" document, provided by Nurse B at approximately 4:50 p.m.. The report, dated 10/08/2023, had an entry for Resident 1 which documented, "Tried to shower on [his/her] own and fell. Has a skin tear." Nothing further was documented. At that time, Nurse B confirmed s/he did not have any additional information indicating whether Resident 1 was assessed for other injuries after his/her fall or any additional information about his/her resulting skin tear.

At approximately 5:17 p.m., Surveyor interviewed Administrator A. Administrator A reported s/he was unaware of Resident 1's skin tears. Administrator A acknowledged Surveyor's concern that it wasn't clear how staff monitored or assessed Resident 1 for any additional injuries after his/her reported and documented falls or how they cared for Resident 1's skin tears, the most recent of which did not contain any details about the tear, based on the information in his/her record.