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	0019492	A. BUILDING: _____ B. WING _____	C 11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 000	Initial Comments On 10/24/2024 with additional information gathered through 11/01/2024, Surveyor conducted two complaint investigations at Carrington Assisted Living. As a result four deficiencies were identified. Two of 2 complaints were substantiated. Census: 16	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 interviews, the provider did not take immediate steps to ensure the safety of all residents, thoroughly investigate,	N 158		

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

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document and/or report to the department when necessary allegations of potential neglect and/or mistreatment of residents.

On 09/01/2024 at 11:54 AM, the provider became aware of an allegation of potential neglect and/or mistreatment of Resident 1 by APOA (Activated Power of Attorney)-A. APOA-A reported Resident 1 fell during the night shift on 08/31/2024 and was calling out for an hour and laying on the floor for a half hour. APOA-A also reported during this shift Resident 1 was not checked on from 3 AM until 5:30 AM and the fall was not documented. The provider did not take immediate steps to protect all residents from subsequent incidents of misconduct and document a thorough investigation. Additionally, the provider allowed suspected staff to continue to care for residents in the facility pending the results of the investigation.

Findings include:

Prior to initiating the survey on 10/24/2024 and again on 10/28/2024, Surveyor reviewed Department records and noted the facility had not submitted any Misconduct Incident Reports (MIR) or self-reports documenting investigations into allegations of abuse, neglect, and/or mistreatment of a resident any time after 06/2024.

On 09/25/2024, the Department received a complaint regarding concerns with staff response to a resident fall.

The facility's policy and procedure titled "Reporting and Investigating Caregiver Misconduct" revised 09/10/2019 indicated, "It is the policy of this community that employees

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N 158	Continued From page 2 immediately report all witnessed or suspected incidents of Caregiver Misconduct as defined in DHS 83.12(2)(a) & DHS 13...Procedure: Reporting Caregiver Misconduct: 1. Employees shall immediately: a. Report witnessed or suspected incidents of caregiver misconduct to the community administrator (in person or by telephone) AND leave a detailed message on the Community Hotline ...b. Complete, sign and date a Grievance Form (see Grievance Policy & Procedure) detailing the suspected misconduct and deliver the completed form to the Administrator. 2. An employee witnessing or suspecting misconduct may not leave the premises without notifying the administrator (in person or by telephone), calling the Community Hotline and completing a Grievance Form. 3. Upon notification (same day), the administrator (or the designee if the administrator is unavailable) will immediately remove the caregiver suspected of misconduct from the premises by suspending the caregiver with pay pending an internal investigation. 4. The administrator will preserve any physical evidence that may be available; interview all involved parties (including the resident): notify the resident's representative / guardian / case worker (if applicable); and notify the local law enforcement agency if evidence suggests there has been misconduct. 5. The administrator shall, after conducting the investigation, determine if there is reasonable cause to believe there is sufficient evidence or sufficient evidence could be obtained and there is reasonable cause to believe the incident meets or could meet the definition of abuse, neglect, or misappropriation. Employees with evidence of misconduct shall be terminated and. within 7 days of the allegation, be reported to: Department of Health & Family Services..."	N 158		

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N 158	Continued From page 3 On 10/24/2024, Surveyor reviewed the closed medical record for Resident 1. The resident was admitted to the facility on 05/28/2024 with an APOA and diagnosis to include Alzheimer's. On 09/03/2024, APOA-A moved Resident 1 out of the facility. Resident 1's ISP (Individual Service Plan) dated 07/24/2024 indicated, Resident 1 was receiving hospice services, required staff assistance with ADL's and toileting. Additionally, the ISP indicated Resident 1 did not ambulate, required assistance with incontinence briefs and indicated, "[Resident 1] has a camera in room view. POA is ok with camera being covered up when cares are being done or when changing resident..." Review of Resident 1's Hospice visit notes dated 09/1/2024 at 10:18 AM indicated, "Received a call from [APOA-A] reporting [Resident 1] had a fall last night at the facility. [APOA-A] has cameras in the room and [s/he] was able to see [Resident 1] was on the floor for about 45 minutes before staff found [Resident 1]; [s/he] was calling out... [APOA-A] expresses concerns about current living situation...Writer let [APOA-A] know a nurse would be sent to assess...On 9/1/2024 at 11:42 AM, PRN (as needed) visit made to check on reported fall from [APOA-A] reporting [Resident 1] fell to floor last night between 2-3:00 AM- Notes today [s/he] has had decline, continued restlessness/discomfort...Notes nighttime has no recording of fall last night..." A fall incident report for Resident 1 dated 09/01/2024 at 10:39 PM indicated, "On 08/31/2024 [Resident 1] was found on the floor around 2 AM. Staff was assisting three other residents when assisting one resident being closer to [Resident 1's] room, Staff hard [Resident 1] yelling...Staff finished up with resident and	N 158		

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went to [Resident 1's] room and seen [Resident 1] was laying on the floor...Staff did ROM (range of motion)/vitals and 2 assisted back to bed. Staff changed the resident brief and administered PRN medication..."

On 10/25/2024 at 12:05 PM, Surveyor interviewed APOA-A. APOA-A indicated s/he placed a camera in [Resident 1's] room sometime in July 2024. APOA-A stated, "I viewed my camera footage in the morning on 09/01/2024 and noticed [Resident 1] started calling out for help at 2 AM and then the camera showed [Resident 1] on the floor at 2:25 AM. Staff did not come in until 2:55 AM. When staff came in, they covered the camera and put [Resident 1] to bed. I could hear [Resident 1] crying. Staff gave [her/him] medication and closed the blinds. [Resident 1] was crying, and staff walked out like nothing happened. Staff never checked [Resident 1] over, never took vitals or updated me and/or hospice. No one bothered to see why [Resident 1] was crying or if [s/he] was hurt. No one checked on [her/him] again until 5:30 AM." APOA-A went on to say, "After watching the camera footage back the morning of 09/01/2024, I called the facility to check on [Resident 1] because I noticed [s/he] fell. The AM shift knew nothing about a fall and no fall was documented. I then sent [AA (Assistant Administrator)-B] a text message on 09/01/2024 about what I witnessed on the video. [AA-B] said [s/he] would look into it, but I never heard anything, and the night shift staff continued to work another two days. [AA-B] didn't bother to talk to the staff working because it was a holiday weekend. On 09/03/2024, I went to the facility and showed [AA-B] the camera footage. [AA-B] was upset and said the night shift staff behavior was unacceptable. After seeing this incident on camera, I moved

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N 158	Continued From page 5 [Resident 1] out of the facility on 09/03/2024." On 10/24/2024 starting at approximately 9 AM, Surveyor interviewed AA-B regarding Resident 1. AA-B indicated there was an incident where APOA-A was upset because Resident 1 fell during the night shift and was on the floor for 40 plus minutes. AA-B provided Surveyor with written text messages between APOA-A and AA-B. The text messages revealed the following: On 09/01/2024 at 10:42 AM, APOA-A sent a text to AA-B and stated, "This is [APOA-A]. [Resident 1] fell last night and it was never charted or mentioned to the day staff...[Resident 1] was calling out for an hour and was lying on the floor for half hour. Complains of being sore this morning. No check from 3-5:30 AM. Hospice is heading over to evaluate [her/him]. NOT HAPPY." On 09/01/2024 at 11:54 AM, AA-B responded with a text message back to APOA-A and stated, "Thank you for confirming this to me as will [sic] as first shift reported to me as will [sic]. I will conduct an investigation and get to the bottom of this with my night shift staff. I'm not happy as will [sic]." Surveyor then asked for the facility's investigation into the above allegation. A typed document by AA-B was given to Surveyor. The document was written by AA-B and indicated, "On 09/01/2024 at 9:33 AM-Writer received a call from [Caregiver-D] asking if I was aware of a fall that [Resident 1] had. I stated I was not aware and asked what happened. [Caregiver-D] said the APOA informed [her/him] [Resident 1] had a fall on night shift, and no one called [her/him] about it. I asked [Caregiver D] if there was an incident report and [Caregiver D] stated there was not one. I ended the call to start looking into the incident. I checked ECP and noted there was not an	N 158		

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N 158	Continued From page 6 incident report present but there had been medication administered. I attempted to contact the caregivers working the night shift on 08/31/2024. I was not able to make contact with them and left messages asking them to return my call-in regard to the incident. On 09/03/2024 at 9:47 AM, after returning to work from the holiday weekend, I started to look further into the incident...at 12:30 PM, [APOA-A] brought in a video recording that was going during the incident. Video showed the following: Bed in lowest position, [Resident 1] on right side on floor with mat under [her/him]. [Resident 1] was wearing a T-shirt and brief. [Resident 1] had a pillow and blanket on the floor mat. [Resident 1] was kicking and yelling out. According to the video recording time, staff came into [Resident 1's] room about 40-43 minutes later. Staff covered lens of camera. [Resident 1] could be heard on video yelling out, lens of camera was removed, and resident was in bed. [Resident 1] appeared agitated and uncomfortable. [Resident 1] continued to kick and yell. [Caregiver-E] appeared on the camera and closed the blinds and left the room...[APOA-A] confirmed resident was being moved, effective immediately. [APOA-A] asked if any repercussions were going to come to staff that were involved in the incident. Writer explained that an investigation would be started immediately, and the proper course of action would take place. Writer expressed sincere apology for the incident and sadness in the situation. Writer contacted [Caregiver E and Caregiver F] who were the 2 caregivers working at the time of the incident. Writer told them they were suspended pending investigation. [Administrator G] is covering for management and is on-call ROD (Regional Operations Director). [Administrator G] made aware of the incident."	N 158		

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N 158	Continued From page 7 On 10/24/2024, Surveyor reviewed staff time sheets for August 2024 and September 2024. The time sheets revealed Caregiver E and Caregiver F worked the night shift on 08/31/2024. In addition, the time sheets revealed, Caregiver E worked on 09/01/2024 from 9:52 PM until 6:00 AM and 09/02/2024 from 9:45 PM until 6:24 AM and Caregiver F worked on 09/02/2024 from 2:13 PM until 9:58 PM. ***Surveyor noted Caregiver E and Caregiver F continued to work with residents before the investigation was completed or a formal conclusion was made. On 10/24/2024 at approximately 10:15 AM, AA-B confirmed s/he provided Surveyor with all information and documentation into the alleged incident. AA-B then stated, "I told [Administrator G] who was on call for the owners about the text I received from [APOA-A] and [Administrator G] conducted the investigation and reported it." On 10/24/2024 at approximately 10:30 AM, Manager H told Surveyor s/he was on vacation at the time of this incident, but Administrator G was filling in during her/his absence. Manager H confirmed the incident was not reported to the department but was investigated by Administrator G. On 10/24/2024 at approximately 3:00 PM, Administrator G provided Surveyor with the documented investigation into the alleged incident involving Resident 1 during the night shift on 08/31/2024. Administrator G confirmed s/he provided Surveyor with all documentation of the investigation and verified [s/he] had no additional information or documentation regarding the incident with Resident 1.	N 158		

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N 158	Continued From page 8 Administrator G's and AA-B's undated investigation included the following: *a copy of Resident 1's ISP dated 07/24/2024 *An email dated 09/04/2024 from APOA-A indicating s/he was terminating Resident 1's contract and placement with the facility *A call log report from 08/31/2024 through 09/01/2024 (***The call log report revealed Resident 1's call pendent was not pushed during the night shift on 08/31/2024 but did show Resident 2 waited over two hours and Resident 3 waited 48 minutes for staff to respond to their call pendants during the night. In addition, the 09/01/2024 night shift call log report revealed Resident 4 waited over three hours and Resident 2 waited over two hours for staff to respond to their call pendants.) *An interview with Caregiver E and Caregiver F conducted by phone and dated 09/04/2024. (***Surveyor noted Caregiver E and Caregiver F were not interviewed until 3 days after the provider became aware of the allegation.) Caregiver E and Caregiver F interviews were typed on an investigation form which indicated, "08/31/2024, [Resident 1] was left on the floor for 45 minutes screaming for help. Once staff entered [her/his] room they covered the camera that was placed in [her/his] room before getting [her/him] off the floor." The form had a series of questions that were asked to Caregiver F and Caregiver E and their responses. The interviews revealed both Caregiver E and Caregiver F had a "Busy Night." When questioned if Resident 1 had [his/her] call pendant both Caregiver E and Caregiver F responded they were "unsure" and/or "did not know." Both Caregiver E and F were	N 158		

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asked when Resident 1 was last checked on prior to finding [her/him]. Caregiver F stated, "I'm not sure. I honestly don't know." Caregiver E stated, "Maybe an hour or after or two after the fall." When asked how many rounds were conducted during the shift. Caregiver E stated, "Too many ...We usually do 1-2-hour checks..." Caregiver F stated, "I'm not sure cause we go in there, it could vary..." Caregiver E's and Caregiver F's interview revealed they did not follow proper protocols for documentation and notification following Resident 1's unwitnessed fall.

Surveyor noted documentation of the provider's investigation did not include:
---information on what was done to protect Resident 1 and other residents from potential neglect/mistreatment while the investigation was in progress
---information indicating if Resident 1's routine rounds/checks were documented
---information indicating if Resident 1 was assigned a call pendent and if the call pendent was working properly
---information indicating residents were interviewed to determine if their needs were met or if they had experienced similar incidents
---information into the length of time other residents waited for their call pendants to be answered
---interview with other staff to determine their knowledge of the incident or any inappropriate behavior they witnessed by Caregiver E and F
---information if disciplinary action was taken against Caregiver E and/or Caregiver F regarding the breach in protocols
---the conclusion of the investigation or determination if a MIR (Misconduct Incident Report) should be submitted to the department

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N 158	Continued From page 10 On 10/30/2024 at 1:30 PM, Surveyor interviewed Administrator G regarding the above investigation. Administrator G verified the investigation did not include any of the above information and the conclusion to the investigation was not complete. Administrator G stated, "[AA-B] did not tell me about the allegation until 09/04/2024. On 09/04/2024, [AA-B] and I conducted interviews with the accused staff over the phone. I was just suppose to question the accused staff and [AA-B] was suppose to do the rest of the investigation. I was limited to what I could do because I was at home sick and could not go into the building. [AA-B] should've completed a summary and conclusion of the investigation." The provider did not take immediate steps to protect all residents from subsequent incidents of misconduct or conduct and document a thorough investigation after receiving the allegation. Additionally, Caregiver E and Caregiver F continued to care for residents in the facility pending the results of the investigation. Cross Reference N0169 DHS 83.12(5)(a) Notification: Incident, Injury, Changes	N 158		
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.	N 169		

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This Rule is not met as evidenced by:
Based on record review and interviews, the provider did not ensure immediate notification to a resident's legal representative and the resident's physician when there was an incident or injury to the resident.

Resident 1 had unwitnessed fall on 09/01/2024 in [his/her] bedroom. Resident 1's physician or legal representative were not immediately notified of the fall. In addition, Resident 1's legal representative was not notified per the resident's plan of care when facility staff administered a PRN (as needed) psychotropic medication after the fall.

Findings include:

On 09/25/2024, the Department received a complaint regarding concerns with staff response to a resident fall.

On 10/24/2024, Surveyor reviewed the closed medical record for Resident 1. The resident was admitted to the facility on 05/28/2024 with an APOA (Activated Power of Attorney) and diagnosis to include Alzheimer's. Resident 1's ISP (Individual Service Plan) dated 07/24/2024 indicated, Resident 1 was receiving hospice services, required staff assistance with ADL's and toileting. Additionally, the ISP indicated Resident 1 did not ambulate, required assistance with incontinence briefs and indicated, "[Resident 1] has a camera in room view. APOA is ok with camera being covered up when cares are being done or when changing resident...Cognitive

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status and Behaviors- Not oriented to date, time or location. Not always able to make safe decisions- Offer PRN medication make sure APOA is notified."

Resident 1's Hospice visit notes revealed the following:

*On 09/1/2024 at 10:18 AM- "Received a call from [APOA-A] reporting [Resident 1] had a fall last night at the facility. [APOA-A] has cameras in the room and [s/he] was able to see [Resident 1] was on the floor for about 45 minutes before staff found [Resident 1]; [s/he] was calling out. Staff arrived and got [Resident 1] back into bed and gave [her/him] some medications ...[APOA-A] reports [s/he] has a hired caregiver with [Resident 1] now and they report [Resident 1] is having some pain and is "sore." ...[APOA-A] reports the night staff did not reach out to [her/him] to update of the fall or meds given and writer does not note staff called hospice to report the fall as far as writer can see. The night staff did not report the fall to the day staff according to [APOA-A]...Writer let [APOA-A] know a nurse would be sent to assess..."

*On 09/1/2024 at 11:42 AM- "PRN (as needed) visit made to check on reported fall from [APOA-A] reporting [Resident 1] fell to floor last night between 2-3:00 AM- Notes today [s/he] has had decline, continued restlessness/discomfort. Writer arrived and greeted at door by [Med Tech-C] writer had [Med Tech-C] pull up PRN medications that were administered last night between 2:30 AM-3:00 AM per APOA-A; [Med Tech-C] noted both lorazepam 0.5mg and haloperidol administered last night at 2:55 AM. Notes nighttime has no recording of fall last night..."

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N 169	Continued From page 13 Resident 1's September 2024 MAR (Medication Administration Record) indicated; Resident 1 received lorazepam 0.5 mg on 09/01/2024 at 2:58 AM. ***Surveyor noted there was no documented evidence staff notified APOA-A regarding the administration of the PRN medication as indicated in the resident's plan of care. A fall incident report for Resident 1 dated 09/01/2024 at 10:39 PM indicated, "On 08/31/2024 [Resident 1] was found on the floor around 2 AM. Staff was assisting three other residents when assisting one resident being closer to [Resident 1's] room, Staff hard [Resident 1] yelling...Staff finished up with resident and went to [Resident 1's] room and seen [Resident 1] was laying on the floor...Staff changed the resident brief and administered PRN medication for restlessness and agitation." The fall incident report indicated the physician was notified on 09/01/2024 at 10:39 PM, over twenty hours after the fall occurred and the legal representative was notified on 09/01/2024 at 10:39 AM. ***It should be noted APOA-A notified the facility of the unwitnessed fall on 09/01/204. On 10/25/2024 at 12:05 PM, Surveyor interviewed APOA-A. APOA-A indicated s/he placed a camera in [Resident 1's] room sometime in July 2024. APOA-A stated, "I viewed my camera footage in the morning on 09/01/2024 and noticed [Resident 1] started calling out for help at 2 AM and then the camera showed [Resident 1] on the floor at 2:25 AM...When staff came in, they covered the camera and put [Resident 1] to bed...Once in bed, staff gave [Resident 1] medication and closed the blinds." APOA-A went on to say, "After watching the	N 169		

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camera footage back the morning of 09/01/2024, I called the facility to check on [Resident 1] because I noticed [s/he] fell. The AM shift knew nothing about a fall and no fall was documented. I then sent [AA (Assistant Administrator)-B] a text message on 09/01/2024 about what I witnessed on the video. Staff never called me about the fall or medication. I called hospice the morning of 09/01/2024 to inform them of the fall and they knew nothing."

On 10/24/2024 starting at approximately 9 AM, Surveyor interviewed AA-B regarding Resident 1. AA-B indicated s/he recalls a fall incident involving Resident 1 during the night shift on 08/31/2024. AA-B provided Surveyor with a written text message between APOA-A and AA-B. The text messages revealed the following: On 09/01/2024 at 10:42 AM, APOA-A sent a text to AA-B and stated, "This is [APOA-A]. [Resident 1] fell last night and it was never charted or mentioned to the day staff...They also gave [Resident 1] a med at 3 AM ...Hospice is heading over to evaluate [her/him]..." On 09/01/2024 at 11:54 AM, AA-B responded with a text message back to APOA-A and stated, "Thank you for confirming this to me as will [sic] as first shift reported to me as will [sic].

On 10/24/2024 at approximately 10:30 AM, AA-B told Surveyor, "On 09/01/2024 at 9:33 AM [s/he] received a call from [Caregiver-D] asking if [s/he] was aware of a fall that [Resident 1] had. [AA-B] stated [s/he] was not aware. [Caregiver-D] said [APOA-A] informed [her/him] [Resident 1] had a fall on night shift. [AA-B] asked [Caregiver D] if there was an incident report and [Caregiver D] stated there was not one. [AA-B] investigated it further and noted there was not an incident report but there had been medication administered."

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N 169	Continued From page 15 AA-B stated "Staff are expected to following protocol after a fall. Staff should have called the physician/hospice provider, [APOA-A] and me right away, but they didn't." On 10/24/2024 at approximately 3:00 PM, Manager B verified Caregiver E and Caregiver F worked the night shift on 08/31/2024 and neither Caregiver E or Caregiver F notified hospice, the physician or APOA-A immediately of Resident 1's unwitnessed fall. Manager B also confirmed Caregiver E and Caregiver F did not document the fall incident timely. Manager B stated, "[AA-B] will be writing up a discipline notice against [Caregiver E and Caregiver F] today for not following our protocols." Cross Reference N0158 DHS 83.12(2)(a) Caregiver: Investigate Abuse and Neglect	N 169		
N 427	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents.	N 427		

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This Rule is not met as evidenced by:
Based on observation, staff, resident, and family interviews the provider did not ensure leisure time activities were provided to meet the interests of the residents affecting all 16 residents.

Findings include:

On 09/25/2024 and 10/16/2024, the department received concerns regarding no activity program.

On 10/24/2024, Surveyor observed a large white dry erase board located in the living room. The dry erase board indicated, "October 24, 2024: 9:00 AM Morning Exercises, 10:00 AM Brain Games, 1:00 PM Balloon Toss, 3:00 PM Art-Craft, 6:00 PM Movie Night."

On 10/24/2024, Surveyor observed an October 2024 activity calendar posted on a bulletin board located outside the medication room. The calendar listed the following activities for 10/24/2024, "9:30 AM Sit and Be fit, 10:00 AM Brain Games, 10:30 AM Coffee and Convo, 2:30 PM Collage Making, 4:00 PM Bingo and 6:00 PM Movie and Popcorn."

On 10/24/2024 from 8:30 AM until 3:00 PM Surveyor made observations while in the facility. Observations showed no activities were offered to residents.

INTERVIEWS

On 10/24/2024 at 11:40 AM, Surveyor interviewed Resident 5's APOA (Activated Power of Attorney)-I. APOA-I indicted s/he visits Resident 5 at the facility three to four days a week. APOA-I stated, "Not a lot of activities go on here. The

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facility has an activity calendar posted but they don't really do any of the things listed. I know [Resident 6] has complained about not having a lot of things to do here."

On 10/25/2024 at 12:05 PM, Surveyor interviewed Resident 1's APOA-A. APOA-A stated, "The facility has no activities. Staff just ignore the residents or put them in front of the TV...Residents are rolled into the TV room and lined up with other residents, and left to sit there for hours with no activities."

On 10/24/2024 at 2:00 PM, Surveyor interviewed Resident 7 in her/his bedroom. Resident 7 stated, "There are no activities here. I've been here well over 6 months and since I moved in we've played bingo 3 times...We used to have exercise once a month and a lot of residents participated, but all of a sudden 3-4 weeks ago it stopped. We have no one that does activities." Surveyor then questioned the activities written on the white board located in the common living room area. Resident 7 stated, "I don't know who writes those activities on that white board, but that white board is a lie, it never happens. I get angry because it's a lie. Those activities never happen...If they actually did the activities written on the white board and calendar I would participate...I want to do things."

On 10/24/2024 at 2:15 PM, Surveyor interviewed Resident 6 in her/his bedroom. Resident 6 indicated s/he has lived in the facility for about 7 months and the activities are "Really bad." Resident 6 stated, "I've played bingo three times since I've been here. The last place I was at we played bingo three times a week and it would get me out of my room. One of the staff members here used to do exercise once a week with us,

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and we all loved it, but that staff member stopped because [s/he] doesn't have the time to do it." Surveyor then asked Resident 6 about the activities listed on the white dry erase board and activity calendar in the common area. Resident 6 stated, "Someone just puts activities on the white board and calendar, but staff never do any of the activities listed on that board or calendar. That board and calendar are just a "Come On" for people coming into the building to make it look like residents are having fun here...I would participate in the activities if they would do them."

On 10/24/2024 at 1:40 PM, Surveyor interviewed Caregiver J regarding activities occurring in the facility. Caregiver J stated, "We haven't been able to do any activities today because it's been crazy busy. Most days we can do activities but not consistently. We can't always follow the activities listed on the white board or calendar because it's hard to do it all. I feel the residents would benefit from a designated staff who does activities."

On 10/24/2024 at 1:50 PM, Surveyor interviewed Caregiver K regarding the facility's activity program. Caregiver K stated, "We use to have activity staff, but now the care staff have to do all the activities...The activities listed on the calendar and white board aren't always done or followed if it's busy. We try to do one activity in the morning." Caregiver K confirmed no activities listed on the white board and calendar for 10/24/2024 occurred during her/his shift.

On 10/24/2024 at 3:30 PM, Surveyor shared the above information with AA (Assistant Administrator)-B. AA-B indicated the facility documents daily activities on monthly activity logs for each resident. AA-B verified there were no

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N 427	Continued From page 19 activity logs for any residents during the month of September 2024 or October 2024.	N 427		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on staff interviews and record review, the provider did not ensure Resident 3 and Resident 5 received proper care and treatment within the capacity of the facility. Resident 3 had a current physician's order to receive oxygen 3 liters per minute continuously for "shortness of breath." An observation was made by which the O2 concentrator was set at 5 liters. Additionally, Resident 3's ISP (Individual Service Plan) and eMARs (electronic Medication Administration Record) did not address the resident's oxygen therapy, including the correct oxygen flow rate or the care and treatment of the	Y3244		

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Y3244	Continued From page 20 oxygen supplies/equipment. Resident 5 had a physician's order to receive supplemental oxygen PRN (as needed) for shortness of breath and severe hypoxia. Resident 5's ISP and eMARs did not address the resident's oxygen therapy, including when to change and clean the equipment. Resident 5 had incidents where her/his portable oxygen tank was empty, and staff were not trained on the use of oxygen or the equipment. Findings Include: On 10/16/2024, the Department received a complaint with concerns regarding respiratory care. RESIDENT 3 On 10/24/2024 at 1:40 PM, Surveyor observed Resident 3 seated in his/her room wearing a nasal cannula attached to an oxygen concentrator. The oxygen concentrator was running and set at 5 liters. Surveyor also observed a portable oxygen cylinder secured to the back of Resident 3's wheelchair and noted the cylinder was empty. At 1:45 PM, Caregiver J walked into Resident 3's room and verified Resident 3's portable oxygen cylinder attached to the back of the wheelchair was empty. Caregiver J stated, "[Resident 3] usually stays in [his/her] bedroom and only uses the oxygen concentrator...Sometimes [Resident 3] will use the portable tank with [s/he] comes out for exercise. I will replace the empty tank now." Surveyor asked Caregiver J to verify the oxygen flow rate. It was confirmed Resident 3's oxygen concentrator was running and set at 5 liters. When asked Caregiver J did not know what	Y3244		

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oxygen flow rate was ordered to be administered for Resident 3. Caregiver J stated, "I don't know how many liters [Resident 3] should be getting or what the oxygen concentrator/portable oxygen tank should be set to...The oxygen concentrator is always running so I just leave it run at the liters it's set at."

On 10/24/2024 at 1:45 PM, Surveyor interviewed Caregiver K regarding Resident 3. Caregiver K indicated Resident 3 receives continuous oxygen therapy and indicated the oxygen flow rate on Resident 3's oxygen concentrator should be set at 4 liters per minute.

On 10/24/2024, Surveyor reviewed the medical record of Resident 3. The resident was admitted to the facility on 02/07/2022, with multiple diagnoses including Parkinson's, COVID-19 and hypertension. Resident 3's face sheet indicated s/he was receiving Hospice services and was "On Oxygen- 2 portable and stationary 5 liters."

Resident 3's physician's order, dated 03/21/2024, indicated Resident 3 was to receive PRN oxygen at 2 liters/minute per nasal cannula for shortness of breath or hypoxia. A physician's order, dated 10/25/2024, indicated Resident 3 was to receive oxygen at 3 liters/minute per nasal cannula continuously for shortness of breath.

Resident 3's September 2024 and October 2024 eMAR's (electronic Medication Administration Records) were reviewed. The eMAR's did not contain a physician's order for the oxygen and there was no documentation of the dosage, date, or time the oxygen was administered. Additionally, the eMAR's did not address care/maintenance of the oxygen supplies/equipment.

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Y3244	Continued From page 22 Resident 3's ISP dated 10/01/2024 indicated, the resident required staff assistance with ADL's (activities of daily living), including toileting, transfers, and ambulation, with the use of a wheelchair/walker and gait belt. Additionally, the ISP stated, "Resident has Oxygen use monitored continually/PRN 5 liters..." Resident 3's ISP did not reflect the accurate oxygen order regarding the amount of oxygen to be administered. Additionally, Resident 3's ISP did not include information on the care and treatment of the oxygen supplies/equipment, if staff were to check oxygen saturation levels or what the desired oxygen saturation level for Resident 3 should be. On 10/24/2024 at 2 PM, Caregiver J confirmed Resident 3's September 2024 and October 20204 eMARs did not contain a physician's order for the oxygen and there was no documentation of the dosage, date or time the oxygen was administered. On 10/24/2024 approximately 3:30 PM, Surveyor shared concerns with Manager H and Assistant Administrator B regarding the discrepancies in Resident 3's physician's order for oxygen administration, the ISP and staff interviews. Manager H and Assistant Administrator B indicated they would look into it. In conclusion, Resident 3's ISP and eMARs did not address the resident's oxygen therapy, or the care and maintenance of the oxygen supplies and equipment. In addition, facility staff were not following Resident 3's oxygen order as written and the ISP did not reflect the correct oxygen flow rate for Resident 3. RESIDENT 5	Y3244		

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Y3244	Continued From page 23 On 10/24/2024 at 12:20 PM, Surveyor observed Resident 5 up in his/her broda chair receiving oxygen per nasal cannula and the portable oxygen tank was set at 2 liters. On 10/24/2024 at 1:10 PM, Surveyor observed Resident 5 in his/her recliner chair receiving oxygen per nasal cannula and the room concentrator was set at 2 liters. On 10/24/2024, Surveyor reviewed the medical record of Resident 5. The resident was admitted to the facility on 03/28/2023, with multiple diagnoses including dementia, Alzheimer's, and hypertension. Resident 5's face sheet indicated s/he was receiving Hospice services and was on oxygen. Additionally, the face sheet indicated Resident 5 had an activated power of attorney (APOA). Resident 5's physician's order, dated 03/24/2024, indicated Resident 5 was to receive PRN oxygen at 2 liters/minute per nasal cannula for shortness of breath or comfort. Additionally, a physician's order for Resident 5, dated 08/29/2024 indicated, "During episodes of severe hypoxia and shortness of breath increase oxygen PRN to 5 liters/minute per nasal cannula." Resident 5's ISP dated 04/04/2024 indicated, the resident required staff assistance with ADL's, including toileting, transfers, and ambulation, with the use of a wheelchair/walker and gait belt. Additionally, the ISP stated, "CPAP (continuous positive airway pressure): Monitor for leaky mask, skin irritation or pressure sores. Oxygen use monitored continually/PRN ...Provide assistance with CPAP machine with morning and bedtime cares. Provide assistance with oxygen as	Y3244		

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needed." Resident 5's ISP did not include information regarding the amount of oxygen to be administered, when staff should apply the oxygen or adjust the oxygen flow rate, if staff were to check oxygen saturation levels or what the desired oxygen saturation level for Resident 5 should be. Additionally, Resident 5's ISP did not include directions related to the use of the CPAP machine, the oxygen systems (portable vs room concentrator), the care/treatment of the oxygen supplies, or the cleaning and maintenance procedures for the CPAP machine and oxygen equipment.

Resident 5's September 2024 and October 2024 eMAR's were reviewed. The eMAR's did not contain the physician's order for the PRN oxygen and there was no documentation of the dosage, date, or time the oxygen was administered. Additionally, the eMAR's did not address care/maintenance of the CPAP machine or the oxygen systems.

Observation notes for Resident 5 indicated the following:

09/07/2024- "[Resident 5's] O2 machine was beeping, staff checked, and it was turned all the way up. Staff turned it down to 2 L."

09/18/2024- "[Resident 5's] wheelchair oxygen tank was changed to a full one today due to old one being empty."

09/30/2024- "Staff called hospice about getting more oxygen tanks, only 1 left."

10/06/2024- "Staff, make sure we are turning the oxygen tanks that are on the wheelchair off at night and not left on, staff just put a brand-new

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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tank on yesterday morning, and it was completely empty this morning because it was left on all night, we are flying way to fast through the oxygen tanks..."

INTERVIEWS

On 10/25/2024 at 10 AM, Surveyor interviewed Resident 5's FM (Family Member)-M. FM-M stated, "I visit [Resident 5] a few times a week at the facility. [Resident 5's] portable oxygen tank is empty often. When I came to visit on 10/02/2024, [Resident 5] was hooked up to the oxygen concentrator. I wanted to take [Resident 5] outside, but the portable oxygen tank was empty. Staff didn't know how to change the portable tank when it was empty. I've talked to management about this, but nothing changes." FM-M went on to say, "[Resident 5] has had a CPAP since [his/her] admission to the facility. [Resident 5] is supposed to wear the CPAP at night and off in the morning, but staff are not aware of this."

On 10/24/2024 at 11:40 AM, Surveyor interviewed Resident 5's APOA-I who was visiting at the facility. APOA-I indicated s/he visits Resident 5 in the facility three to four times a week. APOA-I stated, "I arrived at 9 AM today to take [Resident 5] to a dentist appointment. Staff transferred [Resident 5] to the broda chair, and we left for the appointment. After we left, I noticed [Resident 5's] portable oxygen tank was empty. I told [Caregiver J] about [Resident 5's] empty portable oxygen tank when we returned, and [Caregiver J] verified it was empty and replaced it." APOA-I went on to say, "About 3 weeks ago I was visiting [Resident 5] during lunch and [Resident 5's] portable oxygen tank was empty. I told [Caregiver D] [Resident 5's] portable tank was empty, but [s/he] didn't know how to switch it out

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	0019492	A. BUILDING: _____ B. WING _____	C 11/01/2024

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for a full tank. I was told [Resident 5's] portable oxygen tank couldn't be switched out until [Assistant Administrator B] arrived because [s/he] was the only one who knew how to switch out a portable oxygen tank."

On 10/24/2024 at 12:45 PM, Surveyor interviewed Caregiver J regarding Resident 5. Caregiver J verified s/he replaced Resident 5's empty portable oxygen tank with a full one when Resident 5 returned from his/her dentist appointment on 10/24/2024. Surveyor then questioned Caregiver J if s/he received training from the facility on oxygen equipment and when/how to replace a portable oxygen tank. Caregiver J stated, "I've worked here since 05/2024 and haven't received any training on oxygen equipment. I know how to switch out a portable oxygen tank from doing it at my previous job." Caregiver J confirmed Resident 5 had been receiving oxygen and the administration of oxygen was not recorded on Resident 5's eMARs. Caregiver J verified there were no directions listed on Resident 5's eMARs or current plan of care regarding the amount of oxygen to be administered. Caregiver J also confirmed the eMARs and plan of care did not have directions for when staff should apply the oxygen, adjust the oxygen flow rate, or if staff were to check oxygen saturation levels. Caregiver J stated, "I believe [Resident 5] is supposed to receive 2 liters of oxygen when [s/he's] hooked up to the portable oxygen tank and 3 liters when [s/he's] hooked up to the room concentrator...I just go off what the hospice nurse tells me when [s/he] comes in to see [Resident 5]."

On 10/24/2024 at 1:15 PM, Surveyor interviewed Caregiver K regarding Resident 5. Caregiver K

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verified Resident 5 receives oxygen therapy via the oxygen room concentrator or portable oxygen tank. Surveyor asked Caregiver K is s/he received training regarding oxygen equipment and when/how to replace an empty portable oxygen tank. Caregiver K stated, "I've worked in this industry for eight years and know how to switch out portable oxygen tanks, but I've never been trained by this facility."

On 10/24/2024 at 3:05 PM, Surveyor interviewed Manager H and Assistant Administrator B regarding oxygen use and oxygen equipment for residents. Manager H verified the facility did not have a policy and procedure regarding oxygen use, equipment and/or storage. Both Manager H and Assistant Administrator B confirmed they had no documented evidence staff were trained on the use of oxygen or the equipment. Manager H stated, "I will have [Nurse Practitioner L] provide training on oxygen orders and equipment on 10/25/2024 during the monthly staff meeting."

On 10/30/2024 at 2:37 PM, Manager H sent Surveyor an email with multiple attachments and wrote, " ...An in-service was completed with staff..." The attachments indicated Manager H and Nurse Practitioner L educated staff during a mandatory meeting on 10/25/2024, regarding entering a med order for oxygen into ECP and how to use an oxygen concentrator, oxygen tank and how to transfer between them.

In conclusion, Resident 5's ISP and eMARs did not address the resident's oxygen therapy, including the care and maintenance of respiratory supplies or oxygen equipment. Resident 5 had incidents where her/his portable oxygen tank was empty, and staff were not trained on the use of oxygen or the equipment.

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