STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009962	A. BUILDING: _____ B. WING _____	R-C 03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIL DEER HAVEN	N26 W26286 QUAIL HOLLOW RD PEWAUKEE, WI 53072

(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 From 02/27/2024 to 03/01/2024, Surveyor conducted a complaint investigation and verification visit at HIL Deer Haven, a CBRF in Pewaukee. Seven deficiencies were identified. One deficiency was a repeat deficiency - See Statement of Deficiency (SOD) MQKN11, dated 11/10/2022, MQKN12, dated 06/14/2023 and MQKN13, dated 10/04/2023. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 6	{N 000}		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure the individual service plan (ISP) of 3 of 7 residents reviewed was followed. Resident 2 did not receive the dietary assistance or diet indicated on his/her ISP. Resident 3 and Resident 5 did not have their weights monitored as indicated on their ISPs Findings include: From 02/27/2024 to 03/01/2024, Surveyor conducted a complaint investigation alleging concerns with the providers care. On 02/27/2024 from 6:45 a.m. to 8:15 a.m., Surveyor made	N 388		

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

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N 388	Continued From page 1	N 388		

observations and reviewed resident records, which identified the following concerns:

Example 1 - Resident 2:

On 02/27/2024 at approximately 7:54 a.m., Surveyor observed House Manager B bring Resident 2 to the dining room table to eat. Resident 2 was served a bowl of Reeses Puff cereal, an English muffin and yogurt. Surveyor observed this was the same breakfast served to other residents earlier. From 7:55 a.m. to approximately 8:13 a.m., Resident 2 ate his/her meal by him/herself, with staff walking past him/her while they tended to other residents. Resident 2 did not receive any cuing from staff. Surveyor did not observe Resident 2 put his/her utensil down between bites.

On 02/27/2024 at approximately 8:30 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 11/23/2020 with diagnoses including diabetes, developmental disability and cerebral palsy. Resident 2 's ISP, dated 06/14/2023, stated s/he could eat independently but staff should have line-of-sight supervision during meals. The ISP stated Resident 2 was at risk for choking, had a history of eating very quickly and needed reminders to slow down and put his/her utensil down between bites. Resident 2's ISP indicated s/he was on a low sodium, low sugar diet, should be offered no sugar or low sugar snacks and should follow a carb steady diet as much as possible.

On 02/27/2024 at approximately 11:00 a.m., Surveyor interviewed House Manager B and Case Manager E, who was employed by the provider. Surveyor shared observation that the

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dietary needs and assistance identified in Resident 2's ISP were not met. House Manager B commented on Resident 2's dietary needs and stated his/her diet was followed because the yogurt served was low-fat. Surveyor then reviewed the nutrition labels for Resident 2's yogurt, which indicated there was 16 grams of added sugar and Resident 2's cereal, which had 12 grams of added sugar. Case Manager E made note of Surveyor's concern and stated education regarding diabetic diets was needed.

During digestion, sugars and starches break down into blood glucose. Sugars also are known as simple carbohydrates, and starches also are known as complex carbohydrates ... Avoid less healthy carbohydrates, such as foods or drinks with added fats, sugars and sodium. (Source: The Mayo Clinic Website, Diabetic diet: Create your health-eating plan, April 13, 2023, https://www.mayoclinic.org/diseases-conditions/diabetes/in-depth/diabetes-diet/art-20044295 (retrieval date - April 10, 2024).)

Example 2 - Resident 3:

On 02/27/2024 at approximately 8:30 a.m., Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider's facility on 03/17/2003. Resident 3's ISP, dated 09/06/2023, stated, "Weight Management ... [Resident 3] will be weighed weekly at [the provider]... "

On 02/28/2024 at approximately 8:00 a.m., Surveyor requested documentation from House Manager B and Case Manager E of any weights taken of Resident 3 since July 2023.

On 02/28/2024 at approximately 4:00 p.m., House Manager B informed Surveyor no weights

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N 388	Continued From page 3 had been taken because the provider did not have a physician order to obtain weights. Example 4 - Resident 5: On 02/27/2024 at approximately 8:30 a.m., Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider's facility on 02/10/2016. Resident 5's ISP, dated 06/06/2023, stated "Weight Management ... [Resident 5] will be weighed weekly at the home." On 02/28/2024 at approximately 8:00 a.m., Surveyor requested documentation from House Manager B and Case Manager E of any weights taken of Resident 5 since July 2023. On 02/28/2024 at approximately 4:00 p.m., House Manager B informed Surveyor no weights had been taken because the provider did not have a physician order to obtain weights.	N 388		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medications were kept locked with the key only available to personnel identified by the CBRF. The facilities medication cabinet was unlocked and medications were sitting out on a dining room table, kitchen counter and desk. This is a repeat deficiency. See Statement of Deficiency 2WMQ11, dated 10/10/2017 and MQKN11, dated 11/10/2022.	N 419		

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N 419	Continued From page 4 Findings include: The facility is licensed to serve up to 8 residents with developmental disabilities. On 02/27/2024 at approximately 6:50 a.m., Surveyor toured the provider's facility. Surveyor observed 3 binders on a kitchen counter and 3 binders on a dining room table. Each binder had medication packets underneath them and accessible. Surveyor then observed the facility's medication cabinet was unlocked. Six residents were present at the facility during this time, one of which was Resident 6 who was ambulatory. While the medications were stored underneath binders in the common area, Surveyor observed Caregiver K walk throughout the facility, away from the counter and dining room table, to tend to residents. On 02/27/2024 at approximately 7:00 a.m., Surveyor interviewed Caregiver K. Caregiver K stated s/he placed the medications under resident binders because s/he was getting ready to pass the medications. Caregiver K believed the medications were "out of reach" being stored under resident binders. On 02/27/2024 at approximately 7:51 a.m., Surveyor observed Resident 2's Florajen Acidophilus sitting on a desk in the facility's kitchen in clear sight. Staff were tending to residents, away from the desk. On 02/27/2024 from 7:00 a.m. to 7:30 a.m., Surveyor observed Caregiver K tell Resident 6 to sit down 5 times when s/he would rise from a couch in the living room.	N 419		

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N 419	Continued From page 5 On 02/27/2024 at approximately 8:20 a.m., Surveyor interviewed Case Manager E, who worked for the provider. Case Manager E informed Surveyor Resident 6 was often redirected because s/he would "get into things [s/he] shouldn't." On 02/27/2024 at approximately 8:30 a.m., Surveyor reviewed Resident 6's ISP, dated 03/09/2023. The ISP indicated Resident 6 had a history of eating foods s/he should not, but did not indicate s/he had a history of "getting into things" and should have his/her activity limited throughout the facility. On 02/27/2024 at approximately 11:00 a.m., Surveyor reviewed concern with House Manager B and Case Manager E that medications were observed unsecured throughout the facility. House Manager B stated staff would be written up.	N 419		
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	N 431		

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N 431	Continued From page 6 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 the health of residents was monitored and changes in resident health were documented in resident records. Resident 7's change in behavior was not documented in his/her record. Findings include: From 02/27/2024 to 03/01/2024, Surveyor conducted a complaint investigation alleging the provider did not administer medications as prescribed. On 02/27/2024 at approximately 9:45 a.m., Surveyor interviewed House Manager B regarding Resident 7's medications and behaviors. House Manager B stated Resident 7 did not receive some of his/her medications for	N 431		

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N 431	Continued From page 7	N 431		

awhile because the provider needed a prescription refill. House Manager B stated Resident 7 had a change in his/her behaviors at that time.

On 02/27/2024 at approximately 11:00 a.m., Surveyor reviewed Resident 7's record. Resident 7 was admitted to the provider's facility on 03/17/2003 with diagnoses including autism and developmental disability. Surveyor reviewed Resident 7's progress notes, dated 12/01/2023 to 02/16/2024. Progress notes did not include any documentation of behaviors.

On 02/27/2024 at approximately 3:30 p.m., Surveyor interviewed Resident 7's guardian, Guardian L. Guardian L shared concern that Resident 7 missed 2 psychotropic medications for several weeks while residing at the provider's facility without Guardian L being aware. Guardian L stated s/he noticed a change in Resident 7's behavior, including being very anxious during a telehealth appointment. Guardian L stated s/he never got a clear answer as to why the medications were missed.

On 02/28/2024 at approximately 4:00 p.m., Surveyor reviewed Resident 7's Medication Administration Record (MAR), dated 10/19/2024 to 01/13/2024. The MAR documented Resident 7's Carbamazepine 200 mg (Start Date: 08/05/2011) - Take 1 tablet 2 times daily for autism/personality disorder was not administered from 12/14/2023 to 01/10/2024 and Resident 7's Risperidone 1 mg (Start Date: 07/09/2015) - Take 1 & ½ tablets by mouth at bedtime for psychosis were not administered from 12/14/2023 to 01/10/2024.

On 02/28/2024 at approximately 8:00 a.m.,

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N 431	Continued From page 8 Surveyor requested documentation of Resident 7's change in behaviors while off his/her psychotropic medications. House Manager B did not have documentation of the behaviors, but stated Resident 7 became vocally loud, had rapidly shaking hands while yelling, had increased anxiety, was unable to sit still and woke up more throughout the night than his/her normal sleep pattern. Cross Reference: N0432 DHS 83.38(1)(h) Medication Administration	N 431		
{N 432}	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the CBRF was able to provide medication administration appropriate to 4 of 7 residents reviewed. The provider did not ensure a system to ensure medication was ordered and available for administration. This is a repeat deficiency. See Statement of Deficiency (SOD) MQKN11, dated 11/10/2022,	{N 432}		

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{N 432}	Continued From page 9 MQKN12, dated 06/14/2023 and MQKN13, dated 10/04/2023. Findings include: From 02/27/2024 to 03/01/2024, Surveyor conducted a verification visit and complaint investigation related to resident medication administration. On 02/27/2024 at approximately 10:00 a.m., Surveyor reviewed resident records and medications available at the facility. The following concerns were identified: - Resident 3 was admitted to the provider's facility on 03/17/2003. Resident 3's physician orders included Chlorhexidine Gluconate .12% mouthwash (Start Date: 08/05/2011) - Use 2 times per day. Surveyor was unable to locate the mouthwash in the facility's medication cabinet. House Manager B stated Resident 3 had been out of mouthwash since 02/23/2024, but that s/he had called for a refill. - Resident 2 was admitted to the provider's facility on 11/23/2020. Resident 2's physician orders included Potassium Chloride (Start Date: 06/21/2021) - Take 1 tablet every morning, Vitamin D3 1000 Unit - Take 1 tablet every morning and Simvastatin 40 mg - Take 1 tablet at bedtime. Resident 2's MAR, dated 02/08/2024 to 02/27/2024, indicated Resident 2 did not receive his/her Potassium Chloride, Vitamin D3 or Simvastatin from 02/11/2024 to 02/23/2024. House Manager B stated s/he had contacted the physician for refill, but there was a delay in receiving the refill. - Resident 5 was admitted to the provider's facility on 02/10/2016. Resident 5's physician orders included Divalproex 250 mg (Start Date:	{N 432}		

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{N 432}	Continued From page 10 10/14/2019) - Take 1 tablet 2 times daily, Fluoxetine 20 mg (Start Date: 10/11/2018) - Take 1 tablet every morning, Risperidone 2 mg (Start Date: 10/24/2012) - Take 1 tablet 2 times daily and Trazadone 50 mg (Start Date: 11/29/2022) - Take 1 tablet every night. Resident 5's MAR indicated Resident 5 did not receive his/her Divalproex, Fluoxetine, Risperidone or Trazadone as prescribed form 02/11/2024 to 02/23/2024. House Manager B stated s/he had contacted the physician for refill, but there was a delay in receiving the refill. On 02/28/2024 at approximately 4:00 p.m., Surveyor reviewed Resident 7's record. Resident 7 was admitted to the provider's facility on 03/17/2003. Resident 7's physician orders included Carbamazepine 200 mg (Start Date: 08/05/2011) - Take 1 tablet 2 times daily and Risperidone 1 mg (Start Date: 07/09/2015) - Take 1 & ½ tablets by mouth at bedtime. Resident 7's MAR, dated 10/19/2024 to 01/13/2024 indicated Resident 7 did not receive his/her Carbamazepine or Risperidone from 12/14/2023 to 01/10/2024. House Manager B stated Resident 7's medications were missed because s/he needed a prescription refill and then after not receiving the medications for a while, Guardian L requested that Resident 7 remain off the medications. House Manager B stated Resident 7's psychotropic medications were re-started once Guardian L noticed the change in behaviors. House Manager B did not have documentation to confirm when or how often Resident 7's physician had been contacted. Cross Reference: N0431 DHS 83.38(1)(g) Health Monitoring	{N 432}		

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N 454	Continued From page 11	N 454		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person	N 454		

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N 454	Continued From page 12 administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the record of 6 of 6 residents' routine health examinations were maintained. Findings include: On 02/27/2024, Surveyor conducted a complaint investigation alleging concerns with resident weights. On 02/27/2024 at approximately 8:20 a.m.,	N 454		

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HIL DEER HAVEN	N26 W26286 QUAIL HOLLOW RD PEWAUKEE, WI 53072

(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 454	Continued From page 13 Surveyor requested documentation of 6 of 6 residents' weights from House Manager B. House Manager B stated weights were monitored by the residents physicians and only monitored by the facility if there was a physician order to do so. On 02/28/2024 at approximately 7:45 a.m., Surveyor requested the most recent physicals of Resident 1, Resident 2, Resident 3, Resident 5, Resident 6 and Resident 8 from House Manager B and Case Manager E, who was employed by the provider. On 02/28/2024 at approximately 3:40 p.m., House Manager B and Case Manager E stated they would get Surveyor documentation of physicals by 03/01/2024 because they needed to go through paperwork. On 03/01/2024 at approximately 12:00 p.m., Case Manager E followed up with Surveyor and stated it was the provider's policy to not keep yearly physicals once records were batched from the previous year. Case Manager E was unable to provide documentation of the most recent physical for 6 of 6 residents.	N 454		
Y3234	50.09(1)(e) Treatment (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: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed,	Y3234		

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Y3234	Continued From page 14 certified or registered providers of health care and pharmacists with whom the resident comes in contact. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 6 residents were treated with courtesy, respect and full recognition of the resident's dignity. Resident 2 was left alone in the shower for approximately 40 minutes. Resident 2 was not provided guidance with his/her dressing in a respectful manner and in full recognition of his/her dignity. Resident 6 was prohibited from ambulating throughout the home. Findings include: On 02/27/2024 from approximately 6:45 a.m. to 8:10 a.m., Surveyor observed caregiver interactions with residents and identified the following concerns: Example 1 - Resident 2: On 02/27/2024 at approximately 6:45 a.m., Surveyor arrived to the provider's facility. On 02/27/2024 from approximately 6:45 a.m. to 7:20 a.m., Surveyor observed Caregiver K go between the 2 common areas and kitchens in the provider's facility, redirecting residents and	Y3234		

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Y3234	Continued From page 15	Y3234		

administering medications.

On 02/27/2024 at approximately 7:20 a.m., Surveyor overheard Caregiver K rise abruptly from the dining room table s/he was completing medication administration at and state, "Oh my gosh, [Resident 2]." Surveyor followed Caregiver K to a bathroom, where Resident 2 was sitting in the shower. Caregiver K then provided Resident 2 with a towel and assisted him/her to his/her bedroom. Surveyor asked Caregiver K how long Resident 2 had been in the shower. Caregiver K stated s/he assisted Resident 2 with washing up prior to Surveyor's arrival.

On 02/27/2024 at approximately 7:20 a.m., Surveyor observed Caregiver K assist Resident 2 into his/her room. Caregiver K then instructed Resident 2 to get him/herself dressed. From approximately 7:28 to 7:44 a.m., Surveyor observed Caregiver K loudly voice instructions, such as "[Resident 2], put your pants on" and "[Resident 2], put your socks on," from the facility's dining room and kitchen to Resident 2, who was in his/her bedroom attempting to dress him/herself with the door wide open. Surveyor did not observe Caregiver K walk into Resident 2's room to see what task s/he was working on. Surveyor could hear Resident 2 making non-sensical noises and observed Resident 2 with his/her depends and pants by his/her knees.

On 02/27/2024 at approximately 7:49 a.m., Surveyor heard House Manager B state, "[Resident 2]'s food is getting cold." House Manager B then went into Resident 2's room to assist with dressing.

On 02/27/2024 at approximately 8:00 a.m., Surveyor interviewed Caregiver K regarding

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Y3234	Continued From page 16	Y3234		

Resident 2's shower. Caregiver K stated s/he started Resident 2's shower at approximately 6:40 a.m. Caregiver K stated Resident 2 was able to turn the water off by him/herself and would have been able to transfer him/herself out of the shower, but his/her wheelchair was not within reach. Caregiver K stated Resident 2 was "okay" to be left in the shower.

On 02/27/2024 from approximately 7:20 a.m. to 8:15 a.m., Surveyor observed Resident 2 unable to make his/her needs known and that Resident 2 had limited to no movement of his/her right upper extremity.

On 02/27/2024 at approximately 8:30 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on 11/23/2020 with diagnoses including developmental disability and cerebral palsy. Resident 2's individual service plan (ISP), dated 06/14/2023, indicated s/he needed supervision with showers, required assist with transfers. s/he was at risk of falls particularly due to the immobility of his/her right arm and the inability to grasp a railing with the right hand and may need assistance with dressing.

On 02/27/2024 at approximately 11:00 a.m., Surveyor interviewed House Manager B and Case Manager E. Surveyor shared observation that Resident 2 was left unattended in the shower for approximately 40 minutes and left to dress him/herself in his/her room with the door open and Caregiver K calling out instructions as s/he walked throughout the house. House Manager B sighed and stated, "[S/he] should have gotten [his/her] shower at 5:00 a.m."

Example 1 - Resident 6:

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Y3234	Continued From page 17 On 02/27/2024 from 7:00 a.m. to 7:30 a.m., Surveyor observed Caregiver K tell Resident 6 to sit down 5 times when s/he would rise from a couch in the living room. Resident 6's attempts to rise from the couch did not appear to disturb the other residents. On 02/27/2024 at 7:28 a.m., Resident 6 ambulated to the dining room table and sat down in a chair. Caregiver K stated, "[Resident 6], you cannot be sitting here." Surveyor observed no other individual had been seated at the chair and Resident 6 did not appear to disturb the other residents. There was no food present at the table. On 02/27/2024 at approximately 8:00 a.m., Surveyor interviewed the provider's Case Manager E. Surveyor asked Case Manager E if Resident 6 was independent with ambulation. Case Manager E replied, "Yes." Surveyor asked why Caregiver K would tell Resident 6 to sit down or that s/he could not sit at the dining room table if s/he was independent with mobility. Case Manager E replied, "[S/he] gets into things [s/he] shouldn't." Surveyor shared observation that Resident 6 would rise from the couch and immediately be told to sit down and did not appear to be "getting into things." Case Manager E stated Resident 6 should have been able to ambulate as s/he wished. On 02/27/2024 at approximately 8:30 a.m., Surveyor reviewed Resident 6's ISP, dated 03/09/2023. The ISP indicated Resident 6 had a history of eating foods s/he should not, but did not indicate s/he had a history of "getting into things" and should have his/her activity limited throughout the facility.	Y3234		

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Y3235	Continued From page 18	Y3235		
Y3235	50.09(1)(f) Privacy (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: (f) Physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including, but not limited to: This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 6 residents observed were provided privacy while caring for personal needs. Resident 2 and Resident 5 were observed receiving personal cares without privacy. Findings include: On 02/27/2024 from approximately 6:45 a.m. to 8:15 a.m., Surveyor observed residents at the facility and identified the following concerns: Example 1 - Resident 2: On 02/27/2024 at approximately 7:20 a.m., Surveyor observed Resident 2 in the shower with the bathroom door open. Surveyor observed	Y3235		

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Y3235	Continued From page 19 Caregiver K provide Resident 2 with a towel and transfer him/her to his/her wheelchair with the bathroom door open. On 02/27/2024 at approximately 7:20 a.m., Surveyor observed Caregiver K assist Resident 2 to his/her room, instruct Resident 2 to get dressed and then leave Resident 2 in his/her room with the door open. From 7:20 to 7:50 a.m., Surveyor observed Resident 2 attempting to dress him/herself in his/her bedroom with the bedroom door open. Example 2 - Resident 5: On 02/27/2024 at approximately 7:00 a.m., Surveyor observed Resident 5 sitting on the toilet with the bathroom door wide open. Surveyor then observed Caregiver K assist Resident 5 off the toilet and into his/her wheelchair without closing the door for privacy. On 02/27/2024 at approximately 11:00 a.m., Surveyor interviewed House Manager B and Case Manager E. Surveyor discussed concern that Resident 2 and Resident 5 were not provided privacy while personal cares were completed. Case Manager E stated the provider would need to do education. Cross Reference: Y3234 DHS 50.09(1)(e) Treatment	Y3235		