

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0015983</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/12/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>OAK PARK PLACE OF MENASHA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2205 MIDWAY ROAD</b> <b>MENASHA, WI 54952</b>
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N 000	<p>Initial Comments</p> <p>On 03/29/2022, Surveyors conducted an onsite visit at Oak Park Place to complete a standard survey and 9 complaint investigations. The department received five additional complaints and one self report that were also investigated. Additional information was obtained through 05/12/2022.</p> <p>As a result of the survey and investigations, 13 of the 14 complaints were substantiated. One of 14 complaints was unsubstantiated. Nine deficiencies were identified.</p> <p>Census: 39</p>	N 000		
N 214	<p>83.15(3)(a) Administrator shall supervise daily operation</p> <p>The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected.</p> <p>This Rule is not met as evidenced by: Based on record review, observation and interviews, an Administrator did not supervise the daily operation of the CBRF including resident care, services and personnel (training, scheduling, and conducting investigations regarding allegations of neglect and poor resident</p>	N 214		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N 214	<p>Continued From page 1</p> <p>care/service).</p> <p>Findings include:</p> <p>The facility is licensed to provide services for up to 55 residents who may be advanced aged, terminally ill, physically disabled and/or have Alzheimer's/dementia.</p> <p>Between 02/26/2021 and 04/26/2022, the Department received 14 complaints with allegations related to resident neglect and lack of provision of cares, including residents not receiving showers, physical rotating, toileting assistance/changes, bedding changes, and medications as needed. The complaints further alleged the provider had a failing medication system, the Medication Administration Records (MAR) were not being updated and staff were not adequately trained. The complaints indicated issues were reported to supervisory staff without response and/or action regarding the concerns.</p> <p>On 03/29/2022, Surveyors conducted an onsite visit with additional information obtained through 05/12/2022. During the survey, interviews with Caregiver I, Regional RN A and Regional Support Manager B verified there have been changes in management/acting Administrator within the past year, however it remained unclear who was the acting Administrator during different periods of time/events.</p> <p>Note: Providers are required to report to the department when there is a change in Administrator and show verification of Administrator or acting Administrator qualifications when there is a change.</p> <p>On 03/29/2022, Surveyor reviewed the</p>	N 214		

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N 214	<p>Continued From page 2</p> <p>department records to determine when there were changes in Administrator within the past 2 years, however the provider did not report any changes in Administrator.</p> <p>On 03/29/2022 at approximately 9 AM, Surveyor interviewed Caregiver I. When asked how things were going at the facility, Caregiver I stated, "Bad! There's not enough staff and we've reported resident neglect [to management] and nobody does anything..."</p> <p>On 03/29/2022 at approximately 9:30 AM, Surveyor interviewed Caregiver D who stated, "[Former Director J] was the DOH [Director of Housing] and we would report things and [s/he] would always say, 'Don't play the blame game.'"</p> <p>On 03/29/2022 at approximately 11:15 AM, Surveyor interviewed Caregiver F who discussed lack of resident care by the co-workers and further commented, "No one tells us anything like what the cares are supposed to be. No one has trained me on how to access the ISP [Individual Service Plan]."</p> <p>On 03/29/2022 at approximately 11:30 AM, Surveyor interviewed Caregiver G. Caregiver G commented that 3rd shift "is a problem." Caregiver G indicated when s/he comes in at the beginning of 1st shift, there are several residents who are "so wet they need a full bed change done." When asked who is working when residents aren't being changed, Caregiver G replied, "[Caregiver E]." Caregiver G said staff told the old director about Caregiver E but there was no change.</p> <p>On 03/29/2022 at approximately 12 PM, Surveyor interviewed Caregiver H who stated, "When</p>	N 214		

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N 214	<p>Continued From page 3</p> <p>[Former Director J] was here, people [staff] got away with anything. People were no call no show and they didn't stay the whole shift, they'd leave early. ... I have no idea about ISPs, we just go off what people tell us for services. Communication sucks here. Sometimes we don't even know there's a new resident until we see them and we have no idea about cares. There's no med tech [medication passer] on night shift. We would call and tell [Former Director J] and [s/he] would tell me to pass the med [without being trained] and tell me where the key was. [S/he] tried to tell me to pass morphine once; I'm not med trained here." A 03/29/2022, 3 PM interview with Regional RN verified Caregiver H was not a medication passer and should not have been directed to administer medications.</p> <p>On 03/30/2022 at approximately 2:30 PM, Surveyors provided feedback to Regional RN A, Regional Support Manager B and Regional RN Director L regarding deficient practices related to not having qualified/medication trained staff working to meet the medication administration needs of the residents and not having a qualified staff in the CBRF at all times when residents are on the unit. On 04/26/2022 (nearly 1 month later) at approximately 1:00 PM, Surveyor interviewed Regional Nurse Director L who verified there is still not always a trained medication passer on night shift who would be able to administer or assess effectiveness of residents' medications as ordered. Additionally, on 04/26/2022, Surveyor reviewed April 2022 schedule and noted that despite conversation on 03/30/2022 with regional management (RN A, Director C, and RN Director L), there was not a medication passer scheduled for 28 out of 30 3rd shifts or a change in scheduling to ensure the CBRF is not left unattended for 13 out of 30 3rd shifts.</p>	N 214		

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N 214	<p>Continued From page 4</p> <p>On 04/26/2022 at approximately 2:15 PM, Surveyor interviewed Hospice RN M who stated Morphine and Lorazepam had been ordered to be administered through the night and the facility did not have a trained medication passer during night shift on 04/04/2022 or 04/05/2022. Hospice RN M stated s/he had conversations with RN Director L on the orders multiple times as the family reported to him/her that they had to actively request staff to administer the comfort medications. Resident 5 passed away on 04/06/2022.</p> <p>On 04/28/2022 at approximately 4 PM, Surveyor interviewed Home Health Nurse N who was providing in facility wound care services to Resident 17. Home Health Nurse N indicated prior to regional RN A working at the facility, it had been very difficult to find staff including management, was difficult to communicate staff expectations to a responsible party and Nurse N was never confident that there would be the requested follow through. Every visit RN N would leave a note for the facility to reposition Resident 17, check and change bandages because RN N couldn't find anyone to report this to and consistently when RN N came to the facility, these tasks had not been completed as needed. RN N stated, "I couldn't find someone to follow up with to discuss concerns and needed to implement changes to prevent wound from further occurring. ... By my 2nd visit, there was no nurse [Administrator] to give directions to so I gave very simple directions: 'Make sure coccyx is dry at all times and if not, change it to a new dry bandage.' But every time I went [to the facility], bandaging was soaked on [his/her] tailbone; [Resident 17] was soaked!...I pulled [Regional Support Manager B] in a room to show [him/her]</p>	N 214		

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N 214	<p>Continued From page 5</p> <p>how to just change the bandage and that's all [s/he] needed to do but that didn't help. I didn't trust them to do anything else. ... [Regional Support Manager B] asked, 'Well are you teaching staff to do wound care?' but I [RN N] could never find them [staff], but when they were taught, it does not get communicated to others so there was no consistency." RN N reported s/he provided and ordered extra wound care supplies for Resident 17 but when RN N later asked where the supplies were, Regional Support Manager B found them somewhere else, so they had not been available for Resident 17's wound care treatment. RN N stated, "The facility has lack of communication and the process implementation was just awful. This was one of the hardest cases I've ever experienced of wounds and follow up from staff. It's so unnecessary this happened, so unjustified and it's so not fair to the resident or the family! I had a conversation with [Resident 17's spouse] to not blame [him/herself] for this because [Resident 17] will pass away due to [his/her] condition with the wounds."</p> <p>On 04/28/2022 at approximately 4:30 PM, Surveyor interviewed Hospice Nurse O who also verified the care at the facility was unacceptable and it was very difficult to find care staff and/or management staff while in the building or even to get management to return phone calls.</p> <p>On 05/10/2022 at approximately 12:15 PM, Surveyor conducted an email interview with Family P who expressed there were times when administration was responsive and times when they weren't. The family was working with Former Director J in the beginning of March when Resident 17 was admitted, and then communicated with Regional RN A but s/he was only there through 04/01/2022. Each time Family</p>	N 214		
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N 214	<p>Continued From page 6</p> <p>P discovered the manager was no longer there, the family had to reach out to someone at the facility to ask who the new contact should be. After Regional RN A, it was Regional Support Manager B and Regional Nurse Director L. Family P stated it was Former Director J who showed him/her Resident 17's wound and stated s/he would contact their wound care nurse but there was no wound care nurse. Family P stated, "We asked who we could speak to to bring up all of our concerns because there was nothing being done to help [Resident 17] and [his/her] medical care and treatments were not followed." The family was told to contact Regional Support Manager B. There was a meeting scheduled and when Regional Support Manager B observed Resident 17's wounds, "[S/he] said that they have failed [Resident 17] and this will change." At the meeting Home Health Nurse N asked where all the supplies s/he ordered were since Resident 17 had none left. Family P stated, "[Manager B] went up by the front desk in memory care and here was all the boxes. Nobody would open and take anything out and use them and give [Resident 17] [his/her] Ensure. Even [Resident 17's] prescriptions were locked in the nurse's office and nobody went in there to get [Resident 17's] prescriptions and give them to [him/her]. Well time went on [after the meeting] and [s/he] still wasn't getting the care. Now [s/he] is bed ridden. [Manager B] was unreachable. [Resident 17] is referred to hospice. Hospice worker suggested we move [Resident 17] to a better home. ... Still no answer from Manager B."</p> <p>On 05/10/2022 at approximately 1:30 PM Surveyor conducted a phone interview with Family R. Family R stated, "[Resident 17] went downhill so fast those weeks at the facility, I can't imagine the pain [s/he] felt. ... I don't know if there</p>	N 214		
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N 214	<p>Continued From page 7</p> <p>was ever actually anyone in charge. [Regional RN A] was responding by text but I'm not sure there was ever any real follow through. ... [Resident 17] was not eating and we only knew because we observed it, no one communicated to us. I don't even think they communicated between shifts. ...When the family started working with [Regional Support Manager B] after the others were no longer there. [Manager B] was not responding. They either hire unqualified people or they don't train them. [Home Health Nurse N] told us the staff don't know how to use the Hoyer lift, they are going to cause more harm. And they lost [Resident 17's] pain medicine. I don't know if they have any administration left. [Manager B] didn't really know anything. [Hospital Wound Care Nurse T] told us this is the worst case of neglect [s/he's] ever seen in such a short amount of time. [Resident 17] went into the facility with no wounds and [Resident 17] must have been wet or in feces for hours time and again for [his/her] skin to degrade so quickly."</p> <p>Cross Reference: N0214 83.15(3)(a) Administrator Shall Supervise Daily Operation N0239 83.20(2)(a-d) Department Approved Training Courses N0348 83.32(3)(e) Rights of Residents: Free from Mistreatment N0397 83.36(1)(b) Qualified Staff in Charge, On Duty and Awake N0409 83.37(1)(j) Proof of Use Record N0419 83.37(3)(c) Medication Storage: Locked Cabinet N0432 83.38(1)(h) Medication Administration N0504 83.46(1)(c) Heating System Maintenance Y3244 50.09(1)(L) Care</p>	N 214		

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N 239	Continued From page 8	N 239		
N 239	<p>83.20(2)(a)-(d) Department-approved training courses.</p> <p>Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material.</p> <p>Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety.</p> <p>First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking.</p> <p>Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Caregiver E obtained all department approved training as required.</p> <p>Caregiver E was scheduled to conduct medication administration responsibilities and did not have training in medication administration and management.</p>	N 239		

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N 239	<p>Continued From page 9</p> <p>Findings include:</p> <p>On 11/09/2021 and 12/09/2021 the Department received complaints alleging staff are not properly trained causing medication errors and some staff pass medications but have not been trained.</p> <p>On 03/29/2022, Surveyor reviewed Caregiver E's training records to verify compliance with department approved training requirements. Surveyor requested Caregiver E's training records from Regional RN A.</p> <p>Medication Administration</p> <p>On 03/29/2022, Surveyor requested a list of the facility staff who are scheduled to administer medications from Regional RN A. On 03/30/2022 Regional RN A emailed Surveyor stating, "Here is the list of med passers for our building and the shift they work... NOCs [3rd shift] [Caregiver E]..." Surveyor observed Caregiver E was on the list of identified medication passers and Caregiver E was the only 3rd shift medication passer identified on the list. During an interview with Regional RN A on 03/29/2022 at approximately 4pm, Regional RN A verified that when Caregiver E is scheduled, s/he is identified as the caregiver assigned to administer medications.</p> <p>The record for Caregiver E, hired 02/24/2021, did not contain evidence of training or evidence of meeting an exemption for medication administration training. On 03/30/2022, at approximately 2:30 PM, Regional RN A confirmed Caregiver E is identified and scheduled as a medication passer.</p> <p>On 03/30/2022, Surveyor verified Caregiver E was not listed on the Community-Based Care and</p>	N 239		

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N 239	<p>Continued From page 10</p> <p>Treatment training registry or have any other documentation as having completed medication administration training. Caregiver E was not trained/qualified to be scheduled as a medication passer.</p> <p>Surveyor reviewed the facility staff schedules for January 2022 through March 2022 dates which Caregiver E was scheduled. Surveyor cross referenced CCDET Caregiver Training Registry for each caregiver scheduled to work a 3rd shift at the same time as Caregiver E to determine whether they were trained in Medication Administration. The following dates are dates which Caregiver E was scheduled 3rd shift with caregivers who were not identified as Medication Administration certified on CCDET Training Registry and RN A stated Caregiver E was the medication passer: January 12, January 13, February 12, February 26, March 4, March 8, March 12, March 13, March 13, March 17, March 26, March 27, March 30.</p> <p>Cross Reference: N0214 83.15(3)(a) Administrator Shall Supervise Daily Operation N0348 83.32(3)(d) Rights of Residents: Free from Mistreatment N0397 83.36(1)(b) Qualified Staff in Charge, On Duty and Awake Y3244 50.09(1)(L) Care</p>	N 239		
N 348	<p>83.32(3)(d) Rights of Residents: Free from mistreatment</p> <p>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect,</p>	N 348		

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N 348	<p>Continued From page 11</p> <p>and from financial exploitation and misappropriation of property.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility did not ensure all residents were free from mistreatment/neglect.</p> <p>On 03/02/2022, Resident 17 was admitted to the facility with an identified risk and history of poor skin integrity with potential for skin breakdown. Resident 17 required staff assistance with transferring, mobility, and toileting upon admission to the facility. Resident 17 was not receiving cares as identified and often sat in urine-soaked protective undergarments.</p> <p>On 03/13/2022, an open area was identified on Resident 17's coccyx which was reported to staff by Resident 17. Resident 17 required assistance with repositioning. Resident 17's skin condition and overall physical health continued to worsen and on 03/18/2022, Resident 17 was sent to the ER for change in condition and was found to have 2 wounds on his/her bottom. On 03/31/2022, Resident 17 had a wound care appointment and was admitted to Home Health services for wound care and 5 open areas were identified requiring wound care. On 04/15/2022, 5 new wounds were identified and the previously identified wounds continued to worsen. On 04/18/2022, Resident 17 was admitted to hospice and was moved to a skilled nursing facility following diagnosis of gangrene in multiple wounds.</p> <p>Findings include:</p>	N 348		

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NAME OF PROVIDER OR SUPPLIER  <b>OAK PARK PLACE OF MENASHA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2205 MIDWAY ROAD</b> <b>MENASHA, WI 54952</b>
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N 348	<p>Continued From page 12</p> <p>The facility is licensed to provide services for up to 55 residents who may be advanced aged, terminally ill, physically disabled and/or have Alzheimer's/dementia.</p> <p>On 04/22/2022, 04/23/2022, 04/24/2022, and 04/26/2022, the department received detailed complaint information alleging neglect.</p> <p>On 05/03/2022, Surveyor reviewed Resident 17's record and noted Resident 17 was admitted to the facility on 03/02/2022 with diagnoses of thyrotoxicosis, dementia, nocturia (frequent urination at night), chronic pain, and edema. Resident 17 was identified as having poor skin integrity, having a history of open areas to his/her coccyx and being at risk for cellulitis related to increased edema to his/her lower legs. Resident 17 was discharged on 03/02/2022 from Home Health services since Resident 17 did not have any open areas and was admitted to the facility for assisted living care. Resident 17 had resided with his/her spouse who was his/her primary caregiver prior to facility admission.</p> <p>On 05/03/2022, Surveyor reviewed Resident 17's Individualized Service Plan (ISP) last updated on 03/22/2022, which identified the following needs and interventions:</p> <ul style="list-style-type: none"> <li>-Resident [referring to Resident 17] has a decline in cognition ...</li> <li>-Resident has a self care [sic] performance deficit in bathing r/t [related to] memory loss and chronic pain] [Surveyor note: no intervention/task listed]</li> <li>...</li> <li>-The resident has bowel incontinence r/t memory loss, poor mobility, chronic pain ... Assist resident with toileting per resident preference and frequently due to skin breakdown.</li> </ul>	N 348		

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N 348	<p>Continued From page 13</p> <p>Date Initiated 03/17/2022. Revision 03/22/2022 ...</p> <p>-The resident has chronic pain r/t back injuries and surgical intervention ...Encourage and assist resident to: call for assistance when in pain and to request repositioning ...</p> <p>-The resident has potential/actual impairment to coccyx, sacral, and buttock areas. Date Initiated: 03/17/2022 ... Observe skin. Keep skin clean and dry. Hydrate skin with lotion, as needed. Specify any areas that should not have lotion applied. Report any skin alterations to nurse. Date Initiated: 03/17/2022 ...Provide resident with pressure relieving devices (air mattress, hospital bed) as ordered by MD to protect skin integrity. Date Initiated: 03/22/2022 ...Weekly treatment document to include measures of each area[s] of skin."</p> <p>Surveyor note: Resident 17's wound on his/her coccyx was not reported to Regional RN A until 03/13/2022. It was developed and diagnosed to be stage 2 by 03/18/2022.</p> <p>According to WebMD, Stage 2 wound "happens when the sore digs deeper below the surface" of the skin. "Skin is broken, leaves an open wound ... the area is swollen, warm, and/or red. The sore may ooze clear fluid or pus. And it's painful." <a href="https://www.webmd.com/skin-problems-and-treatments/pressure-sores-4-stages#091e9c5e814a712e-2-4">https://www.webmd.com/skin-problems-and-treatments/pressure-sores-4-stages#091e9c5e814a712e-2-4</a> retrieval date 05/11/2022</p> <p>On 05/02/2022 at approximately 4:15 PM, Surveyor obtained written interview information from Resident 17's family member, Family P. Family P reported on 03/18/2022, family was notified that Resident 17 was being taken to the ER for seeming very confused and was very pale. Resident 17 was diagnosed with a urinary tract infection (UTI), malnourishment, and dehydration. Family P stated, "They felt [his/her] pain from [his/her] open sore [on his/her coccyx] and the</p>	N 348		

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N 348	<p>Continued From page 14</p> <p>UTI caused the confusion." Wound care clinic evaluation and home health care referrals were made.</p> <p>Family P shared notes from hospital records from Resident 17's wound care appointment on 03/31/2022, and reported his/her coccyx wound had "gotten worse and was really deep and bad. [S/he] now had another sore on the other side. [His/her] left big toe is bad and left heel. ThedaCare called and sent instructions to Oak Park Place. [Family S] is making copies to bring to Oak Park Place also." Family P shared, it was also found that Resident 17 was found to have an active bilateral (affecting both sides) groin rash and redness and rash under his/her right abdominal fold. Surveyor also noted on hospital records the following diagnoses on 03/31/2022: "Encounter Diagnoses ... -Pressure injury of contiguous region involving left buttock and hip, unstageable ... -Pressure injury of contiguous region involving right buttock and hip, stage 2 ... -Pressure injury of deep tissue of left heel -Chronic ulcer of great toe of left foot, unspecified ulcer stage ... -Blister of left foot, initial encounter ... -Protein malnutrition ... -Stage 3a chronic kidney disease ... -Dementia without behavior disturbance ..."</p> <p>Surveyor note: Resident 17's second wound on his/her bottom and wounds on his/her feet were not identified/reported to facility management or family prior to the wound care appointment on 03/31/2022 showing evidence that staff were not observing skin, keeping skin clean and dry, or repositioning as necessary per Resident 17's ISP.</p> <p>Surveyor reviewed Resident 17's facesheet which</p>	N 348		

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N 348	<p>Continued From page 15</p> <p>noted, "Diagnosis: ...Nocturia [frequent nighttime urination]..." and ISP which noted: "Resident had a self care performance in toileting r/t [related to] poor mobility, memory loss, and chronic pain...BRIEF USE: 2XL disposable briefs. Change, toilet and provide peri-care every two hours and PRN (as needed)... -initiated 03/17/2022 (no revision) Resident has bowel incontinence r/t memory loss, poor mobility, chronic pain. The resident will be continent during daytime. Assist resident with toileting per resident preference and frequently due to skin breakdown. Provide assistance per resident preference with perineal care and offer use of continence products during episodes of incontinence. -revision 03/22/2022 Resident will receive assistance with toileting...BATHROOM ASSISTANCE: Encourage resident to participate as much as possible to promote independence. The resident needs assistance from one of care team members for toilet use. -revision 03/22/2022 The resident has potential/actual impairment to coccyx, sacral, and buttock areas. ... Observe skin. Keep skin clean and dry. Hydrate skin with lotion, as needed. Specify and areas that should not have lotion applied. Report any skin alterations to nurse. Provide resident with pressure relieving devices (air mattress, hospital bed) as ordered by MD to protect skin integrity. Weekly treatment documentation to include measurement of each area(s) of skin breakdown: width, length, depth; type of tissue and exudate; and any other notable changes or observation. Report improvements and declines to the MD-managed by SN. -Date initiated 03/22/2022."</p> <p>On 04/29/2022 at approximately 4:00 PM, Surveyor interviewed Home Health Nurse N (HH Nurse). HH Nurse N was Resident 17's Home</p>	N 348		
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N 348	<p>Continued From page 16</p> <p>Health Nurse prior to admission to the facility and again after re-admission to Home Care services while living at the facility. HH Nurse N stated Resident 17's spouse was a "wonderful caregiver and there were never any issues in [Resident 17's] care while at home." Resident 17 restarted Home Care services on 04/02/2022, and HH Nurse N stated Resident 17 was found to have 2 open areas near his/her coccyx (tailbone), heel of left foot, outer part of left foot, big toe of left foot, and an open area on his/her lateral shin area. The wounds on his/her coccyx and on his/her heel were found to already be considered stage 2 wounds. HH Nurse N reiterated Resident 17 did not have any open areas on his/her tailbone upon discharge from Home Health Care services on 03/02/2022 on the date of admission to the facility, nor did s/he have any skin concerns on his/her feet at that time.</p> <p>HH Nurse N indicated by his/her second visit with Resident 17, it was discussed with family and the facility that the wounds were determined at that time to "already be severe and with no chance of healing without debridement." (The removal of damaged tissue in a wound.) Most of the wounds were considered stage 4 or unstageable.</p> <p>Surveyor note: According to WebMD, "Stage 4 sores are the most serious. The sore is deep and big. Skin has turned black and shows signs of infection - red edges, pus, odor, heat, and/or drainage. You may be able to see tendons, muscles, and bone ...A Stage 4 pressure sore could take anywhere from 3 months or much longer, even years, to heal." ..."unstageable is when you can't see the bottom of the sore, so you don't know how deep it is. <a href="https://www.webmd.com/skin-problems-and-treatments/pressure-sores-4-stages#091e9c5e814a7">https://www.webmd.com/skin-problems-and-treatments/pressure-sores-4-stages#091e9c5e814a7</a></p>	N 348		

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N 348	<p>Continued From page 17</p> <p>12e-2-4 Retrieval date 05/11/2022</p> <p>Per hospital notes provided by Family P on 05/02/2022, Resident 17 underwent 2 debridement procedures on 04/11/2022 to his/her right buttock and left buttock: "Left Buttock: Unstageable : soft, boggy, eschar negative tunneling and undermining currently. Debrided, however unable to assess base [of wound]. The wound is significantly necrotic and the possibility of it extending to bone is high ...will consult general surgery for further assessment and recommendations of possible OR [operation room] debridement and placement of NPWT [wound vacuum]." Resident 17 was found to have 10 active pressure sores at this wound care visit, which was 5 more from what was identified on 03/31/2022.</p> <p>HH Nurse N stated on his/her 3rd and last visit on 04/15/2022 with Resident 17 before admitting to hospice, 2 new wounds were found on Resident 17's right foot. These were not reported to home care staff by provider staff and per HH Nurse N it was obvious that Resident 17 was not being repositioned in bed as often as s/he should have been.</p> <p>HH Nurse N stated this was "one of the hardest cases [s/he] had ever experienced with wounds and neglect from staff." S/he felt the facility had a lack of communication and that the "process implementation was just awful." S/he stated, "It was so unnecessary this happened [to Resident 17], is not justified, and is just not fair to [Resident 17] or [his/her] family."</p> <p>HH Nurse N noted that at every facility visit s/he provided education to staff and left notes for staff on other shifts on how to reposition Resident 17, including how to avoid and relieve pressure points, positioning pillows, placing heel</p>	N 348		

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N 348	<p>Continued From page 18</p> <p>protectors, and how to float Resident 17's heels in bed.</p> <p>HH Nurse N stated after Regional RN A was no longer an employee at the facility, s/he would give very simple directions to staff and "they couldn't even meet the basic care needs" for Resident 17.</p> <p>On 04/29/2022 at approximately 3:30 PM, Surveyor interviewed Hospice Nurse O who stated s/he visited Resident 17 on 04/18/2022, on the day s/he was admitted to hospice, and s/he was moving to a skilled nursing facility (SNF). Hospice Nurse O stated s/he recalled observing 4 wounds on 1 foot, 6 wounds on the other foot (toes, heels, and foot involved), and 2 wounds on Resident 17's bottom. S/he indicated most of the wounds were covered with bandaging, except for 1 wound on his/her foot that s/he described as "odorous, necrotic [aka gangrene, dead skin] smelling." Hospice Nurse O dressed the wound prior to Resident 17 being transferred to the SNF. Hospice Nurse O stated Resident 17 would not have qualified for hospice if it wasn't for how quickly the wounds progressed or how severe they became. The family chose hospice and comfort cares over operational surgery and placement of a wound vacuum given Resident 17's overall condition and chronic conditions. Hospice Nurse O stated s/he was "not surprised there are concerns from family or others regarding the care provided at the facility." Hospice Nurse O stated s/he believed Resident 17's wounds "could have definitely been prevented with repositioning, changing, showering, and providing appropriate cares."</p> <p>On 05/02/2022 at approximately 4:15 PM, Surveyor obtained written interview information from Family P who provided documentation of Resident 17 receiving his/her first shower at the</p>	N 348		

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N 348	<p>Continued From page 19</p> <p>facility on 3/21/2022 (19 days after s/he was admitted to the facility) and received only one other shower prior to transferring to the SNF. In addition, Family P stated, "The lack of care and no patient call button for 3 weeks caused many harmful wounds, pain for [Resident 17]. Pain that [s/he] didn't deserve because of this neglect ... [Resident 17] is now being kept comfortable by hospice care. [His/her] wounds are so bad they will no longer heal [unstageable wounds suspected to be stage 4 and infected with a foul odor and drainage]. [Resident 17's] spouse and [family members] are devastated at the lack of care that was given. [Family members] have had to take off work to fly to Wisconsin to help [Resident 17] and eventually get [him/her] moved out of a horrible situation and into hospice and now required skilled care. This affected [Resident 17's] end of life and the pain that [s/he] has gone through from the lack of care. This saddens the family more than words can tell."</p> <p>On 03/29/2022 at approximately 11:15 AM, Surveyor interviewed Caregiver F who discussed lack of resident care by the co-workers and further commented, "No one tells us anything like what the cares are supposed to be. No one has trained me on how to access the ISP [Individual Service Plan]." At approximately 12 PM, Surveyor interviewed Caregiver H who commented, "I have no idea about ISPs, we just go off what people tell us for services. Communication sucks here. Sometimes we don't even know there's a new resident until we see them and we have no idea about cares. On 05/12/2022 at approximately 8 AM, Surveyors interviewed Regional RN L who stated the ISP drives the care for the residents, but there is also a document called the "Care Card" which is a simplified version. It is a tool kept on the unit that</p>	N 348		
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N 348	<p>Continued From page 20</p> <p>staff reference to know what cares to provide to each resident. On 05/12/2022, Surveyors requested a copy of Resident 17's Care Card. At 10:20 AM, Regional Support Manager B stated, "We were not able to find a care card for [Resident 17].</p> <p>Surveyor requested records from the Home Health and Hospice agency 4 times without success in obtaining.</p> <p>In conclusion, Resident 17 moved into the facility on 03/02/2022 with a known history of poor skin integrity. Resident 17 was found to have developed the following wounds while under the care of the facility: -03/13/2022 - 1 wound -03/18/2022 - 2 total wounds -03/31/2022 - 5 total wounds -04/11/2022 - 10 total wounds -04/15/2022 - 12 total wounds Severity of the wounds varied from stage 2 to stage 4 and unstageable condition. Resident 17 attended a wound care consultation on 03/31/2022, was admitted to home health care services for wound care on 04/02/2022, was discharged from home health on 04/15/2022, admitted to hospice on 04/18/2022, and discharged to a SNF on 04/18/2022, where Resident 17 will spend his/her end of life. This was a result of Resident 17 not receiving appropriate cares that met his/her needs which led to wounds and infection that s/he developed since admission to the facility on 03/02/2022.</p> <p>Cross Reference: N0214 83.15(3)(a) Administrator Shall Supervise Daily Operation N0397 83.36(1)(b) Qualified Staff in Charge, On Duty and Awake</p>	N 348		

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N 348	Continued From page 21 Y3244 50.09(1)(L) Care	N 348		
N 397	<p>83.36(1)(b) Qualified staff in charge, on duty and awake.</p> <p>The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure at least 1 qualified caregiver (successfully completed all applicable training) was present in the CBRF when there were residents present on the unit.</p> <p>Twenty-seven out of 31 3rd shifts reviewed in March 2022 did not have a trained medication passer working in the CBRF.</p>	N 397		

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N 397	<p>Continued From page 22</p> <p>Nineteen out of 31 3rd shifts in March 2022 did not have enough staff working to ensure there was a caregiver able to remain on the separate memory care unit/CBRF (Community-Based Residential Facility) at all times throughout 3rd shift.</p> <p>Feedback was given to the provider by Surveyors on 03/30/2022 stating there needs to be at least 1 qualified caregiver (successfully completed all applicable training) present in the CBRF when there were residents present on the unit. New complaint information was presented to the department in April 2022, therefore Surveyors also reviewed the April 2022 schedule.</p> <p>Twenty Eight out of 30 3rd shifts reviewed in April 2022 did not have a trained medication passer working in the CBRF.</p> <p>Nineteen out of 30 3rd shifts reviewed in April 2022 did not have enough staff working to ensure there was a caregiver able to remain on the separate memory care unit/CBRF (Community-Based Residential Facility) at all times throughout 3rd shift.</p> <p>Findings include:</p> <p>On 02/26/2021, 07/05/2021, 11/09/2021, 12/09/2021, 04/10/2022, 04/23/2022, and 04/26/2022, the department received complaints alleging concerns that the provider did not meet resident's identified care needs, especially on 3rd shift or weekends. Staff do not have adequate training, especially related to medication administration. There are multiple medication errors. Agency staff are not able to access resident care plans/information about the</p>	N 397		

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N 397	<p>Continued From page 23</p> <p>residents. Agency staff are not aware of fire or other emergency procedures specific to the facility. Staff are very difficult to find in the building when assistance is needed and do not answer the phone.</p> <p>Oak Park Place of Menasha CBRF is under the same roof as Oak Park Place RCAC (Residential Care Apartment Complex). Regional RN A verified that as a person enters the front door of the building, the RCAC tenant apartments are to the right, 1st and 2nd floor and the CBRF resident rooms are to the left, with general assisted living on the 1st floor and dementia/memory care, a secured unit on the 2nd floor through a set of closed doors. On 03/29/2022 at approximately 10:30 AM, Regional RN A verified that all caregiver staff cover both the CBRF and RCAC every shift therefore a caregiver has to leave the CBRF to assist in the RCAC. There were 17 CBRF residents and 12 RCAC tenants on the 1st floor and 22 CBRF residents on the 2nd floor memory care unit (unsure how many 2nd floor RCAC tenants). There were at least 3 residents receiving hospice at the time of the visit.</p> <p>On 03/29/2022, Surveyors arrived at the facility and interviewed Caregiver I at approximately 9 AM. Caregiver I informed Surveyor that each shift, caregivers are assigned to either 1st or 2nd floor and the caregiver provides services to both the CBRF residents and the RCAC tenants living on the floor which the caregiver is assigned. Caregiver I informed Surveyor that on 1st and 2nd shift there are usually enough caregivers assigned that if one caregiver leaves the CBRF to provide services to an RCAC tenant, there is still another caregiver in the CBRF. Caregiver I stated on 3rd shift there's often only 2 total caregivers scheduled; the 1st floor caregiver has</p>	N 397		

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N 397	<p>Continued From page 24</p> <p>to leave the CBRF when providing cares to RCAC tenants and the 2nd floor CBRF memory care caregiver has to leave memory care unattended when providing cares to 2nd floor RCAC tenants.</p> <p>On 03/29/2022 at approximately 11:15 AM, Caregiver F stated, "There is often no trained medication passer on 3rd shift which is a problem if any resident or tenant needs medication but also without a 3rd shift medication passer, there's no one for 1st shift to do the narcotics count/proof of use log with so it doesn't get done." Caregiver F also stated that on 3rd shift there is usually only 2 total caregivers for the building and they are assigned per floor so when an RCAC tenant on 1st floor needs help, the 1st floor CBRF is left unattended, and when an RCAC tenant on 2nd floor needs help, the 2nd floor CBRF is left unattended.</p> <p>On 03/29/2022 at approximately 11:30AM, Caregiver G stated, "There is often no trained medication passer on 3rd shift." Caregiver G expressed concerns that if a resident requests medication on 3rd shift, they are not able to get the medication. Also, 1st shift caregivers are not able to complete the narcotics count when 1st shift comes on because there's not a medication passer from 3rd shift to do it with. Caregiver G further verified there is often only 2 total caregivers on 3rd shift and they are scheduled to cover either 1st floor or 2nd floor so the caregiver has to leave the CBRF unattended when providing services to the RCAC tenants. Caregiver G commented about occasional staffing concerns on 1st or 2nd shift and explained that on 1st and/or 2nd shift there are sometimes 2 caregivers working on 2nd floor but when Tenant 8 who needs staff help with full cares and Tenant 6 who is a 2 person assist in</p>	N 397		

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N 397	<p>Continued From page 25</p> <p>the RCAC need help, then 2 caregivers need to be in the RCAC leaving the memory care unit unattended. Caregiver G stated, "Today's morning meds weren't done until after 11 AM because there's only 2 working."</p> <p>On 03/29/2022 at approximately 12 PM, Caregiver H stated, "On 1st shift there's sometimes only 2 caregivers on each floor so the CBRF will be unattended when caring for the RCAC tenants who need 2 person assist." Caregiver H also stated, "Often on 3rd shift there is only 1 person working 2nd floor and you have to leave memory care to help in the RCAC. ... [Tenant 6] and [Tenant 7] (lived in the RCAC) just moved out but they needed help every night." Caregiver H went on to confirm that there's often no medication passer on 3rd shift and informed Surveyor s/he is not a medication passer. S/he said there were times when s/he was working 3rd shift and a resident needed morphine so s/he called Director J (no longer at the facility) who "told me where the key was and tried to tell me to give the morphine." Interview with Regional RN A on 03/29/2022 at approximately 4 PM verified Caregiver H is not a medication passer and should not have been told to pass medication.</p> <p>On 04/26/2022 at approximately 2:15 PM, Surveyor interviewed Resident 5's Hospice RN M who stated the family was in frequent contact with him/her since both Hospice RN M and family members all had difficulties locating staff in the building to assist Resident 5 when needed. Hospice RN M stated s/he had to have multiple parties from hospice make contact with the facility in an effort to actually reach someone to provide updates on Resident 5's care. Surveyor reviewed Resident 5's record and noted Resident 5 had diagnoses of Alzheimer's disease</p>	N 397		

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N 397	<p>Continued From page 26</p> <p>and diabetes mellitus. Resident 5 was receiving end of life care with hospice involvement including administration of morphine and lorazepam as needed for comfort.</p> <p>On 04/28/2022 at approximately 3:30 PM, Surveyor interviewed Resident 17's Hospice Nurse O who stated s/he was at the facility with Resident 17 the day Resident 17 moved from this facility to a nursing home. S/he stated despite staff being aware of Resident 17's discharge time, Resident 17 was not ready and it was very difficult to find staff to assist in getting Resident 17 ready to leave. Hospice Nurse O stated s/he has other patients (residents) s/he works with at the facility and it is very common that it is difficult to find anyone or get a hold of anyone that works there for assistance or to provide updates.</p> <p>On 04/28/2022 at approximately 4:00 PM, Surveyor interviewed Resident 17's Home Health Nurse N who stated it was very difficult to find anyone for assistance during his/her visits with Resident 17 or at the end of his/her visits to provide updates on Resident 17's wound care. Home Health Nurse N stated it was vital to talk with someone regarding Resident 17's care since his/her wounds were worsening. Home Health Nurse N also stated on his/her last visit s/he requested assistance to reposition Resident 17 from a caregiver. The caregiver stated s/he didn't know what to do as s/he hadn't worked with Resident 17 before. Home Health Nurse N noted there were no staff around to assist the caregiver or anyone around who was training him/her.</p> <p>On 04/26/2022 at approximately 2:15 PM, Surveyor interviewed Hospice RN M who stated Morphine and Lorazepam had been ordered to be administered through the night and the facility did</p>	N 397		

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N 397	<p>Continued From page 27</p> <p>not have a trained medication passer during night shift on 04/04/2022 or 04/05/2022. Hospice RN M stated s/he had conversations with RN Director L on the orders multiple times as the family reported to him/her that they had to actively request staff to administer the comfort medications. Resident 5 passed away on 04/06/2022.</p> <p>On 04/26/2022 at approximately 1:00 PM, Surveyor interviewed RN Director L who verified a trained medication passer who would be able to administer or assess effectiveness of Resident 5's comfort medications as ordered was not scheduled on night shift on 04/04/2022 or 04/05/2022.</p> <p>On 03/29/2022 Regional RN A provided Surveyor with a copy of the caregiver schedule for the building. On 03/30/2022 Surveyor reviewed the caregiver schedule with Scheduler K and RN A to ensure Surveyor understood the abbreviations on the schedule. Scheduler K verified "T" is a Caregiver is in training, s/he does not count in the numbers yet. Surveyor reviewed 3rd shift schedule for March 2022 since it had been reported 3rd shift was the primary concern related to having qualified staff (trained in medication administration) on duty as well as having at least 1 caregiver in the area when there are residents who need any level of supervision. The following are the March 3rd shift dates when there were not care staff present in each area of the CBRF at all times due to the caregiver having to leave to provide services in the RCAC and/or when there was not a qualified care staff present due to not having been trained in medication administration: 03/01- 2 caregivers, 0 trained medication passer 03/02- 2 caregivers, 0 trained medication passer 03/03- 2 caregivers, 0 trained medication passer</p>	N 397		
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N 397	<p>Continued From page 28</p> <p>03/04- 1 caregiver, 0 trained medication passer 03/05- 2 caregivers before 2 AM, 1 caregiver after 2AM, 0 trained medication passer after 2 AM 03/06- 2 caregivers, 0 trained medication passer 03/07- 2 caregivers, 0 trained medication passer 03/08- 0 trained medication passer 03/09- 0 trained medication passer 03/10- 2 caregivers, 0 trained medication passer 03/11- 0 trained medication passer 03/12- 0 trained medication passer 03/13- 0 trained medication passer 03/14- 2 caregivers, 0 trained medication passer 03/15- 2 caregivers, 0 trained medication passer 03/16 03/17- 0 trained medication passer 03/18 03/19- 2 caregivers, 0 trained medication passer 03/20- 2 caregivers 03/21- 0 trained medication passer 03/22- 0 trained medication passer 03/23- 2 caregivers, 0 trained medication passer 03/24- 2 caregivers 03/25- 2 caregivers 03/26- 2 caregivers, 0 trained medication passer 03/27- 2 caregivers, 0 trained medication passer 03/28- 2 caregivers, 0 trained medication passer 03/29- 0 trained medication passer 03/30- 0 trained medication passer 03/31- 0 trained medication passer</p> <p>On 03/30/2022 at approximately 2:30 PM, Surveyors interviewed RN A and Director C who verified that a medication passer is not always scheduled on 3rd shift and stated that staffing (finding and retaining) had been an ongoing concern. Surveyors provided guidance informing of the regulatory requirements.</p> <p>In April 2022, additional complaints were reported to Surveyors regarding adequate staffing,</p>	N 397		

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N 397	<p>Continued From page 29</p> <p>therefore Surveyor reviewed the April 2022 3rd shift staffing schedule. The following are the April 3rd shift dates when there were not care staff present in each area of the CBRF at all times due to the caregiver having to leave to provide services in the RCAC and/or when there was not a qualified care staff present due to not having been trained in medication administration:</p> <p>04/01- 0 trained medication passer            04/02- 0 trained medication passer            04/03- 2 caregivers after 2 AM, 0 trained medication passer            04/04            04/05- 0 trained medication passer            04/06- 0 trained medication passer            04/07- 0 trained medication passer            04/08- 2 caregivers, 0 trained medication passer            04/09- 2 caregivers, 0 trained medication passer            04/10- 2 caregivers, 0 trained medication passer            04/11- 2 caregivers, 0 trained medication passer            04/12- 2 caregivers, 0 trained medication passer            04/13- 2 caregivers            04/14- 2 caregivers, 0 trained medication passer            04/15- 0 trained medication passer            04/16- 0 trained medication passer            04/17- 0 trained medication passer            04/18- 2 until 5 AM, 0 trained medication passer            04/19- 0 trained medication passer            04/20- 2 caregivers, 0 trained medication passer            04/21- 2 caregivers after 2 AM, 0 trained medication passer            04/22- 2 caregivers, 0 trained medication passer            04/23- 2 caregivers until 4 AM, 0 trained medication passer            04/24- 0 trained medication passer            04/25- 1 or 2 caregivers, 0 trained medication passer            04/26- 2 caregivers, 0 trained medication passer            04/27- 2 caregivers, 0 trained medication passer            04/28- 2 caregivers, 0 trained medication passer</p>	N 397		

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N 397	<p>Continued From page 30</p> <p>04/29- 0 trained medication passer 04/30- 0 trained medication passer</p> <p>Surveyor noted that despite conversation on 03/30/2022 with regional management (RN A, Director C, and RN Director L), there was not a medication passer scheduled on 3rd shift or a change in scheduling to ensure the CBRF is not left unattended.</p> <p>In conclusion, the provider did not ensure enough staff were scheduled to maintain a staff member in the CBRF at all times 38 out of 61 3rd shifts nor ensure that a qualified staff member who was trained in medication administration was scheduled 55 out of 61 3rd shifts to meet resident needs.</p> <p>Cross Reference: N0214 83.15(3)(a) Administrator Shall Supervise Daily Operation N0239 83.20(2)(d) Department Approved Training Courses N0348 83.32(3)(d) Rights of Residents: Free from Mistreatment N0432 83.38(1)(h) Medication Administration Y3244 50.09(1)(L) Care</p>	N 397		
N 409	<p>83.37(1)(j) Proof-of-use record.</p> <p>Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin 's uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident 's name, the practitioner 's name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and</p>	N 409		

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N 409	<p>Continued From page 31</p> <p>date the proof-of-use records on a daily basis.</p> <p>This Rule is not met as evidenced by: Based on record review, observation, and interview, the provider did not audit, sign, and date the proof-of-use record for schedule II medications on a daily basis.</p> <p>Findings include:</p> <p>The facility is licensed to serve up to 55 residents who may be physically disabled, of advanced age, terminally ill, and/or have irreversible dementia/ Alzheimer's.</p> <p>On 03/29/2022, Surveyor observed the locked narcotic box, within the medication cart on the second floor of the CBRF, to contain at least 3 as needed (PRN) bubble-packed medication cards with schedule II medications and at least 2 PRN sandwich sized bags of morphine syringes, as well as at least 6 scheduled bubble-packed medication cards for various residents in the Memory Care Unit. Surveyor reviewed a binder within the medication cart that included forms of individual count down of use for every medication as well as 1 audit form titled "OPP Menasha Controlled Drugs - Count Record" and "MC [Memory Care] ...March." Surveyor reviewed the controlled substances form which noted, "Initialing below acknowledges that you have counted the controlled drugs on hand and have found that the quantity of each medication counted is in agreement with the quantity stated on the controlled drug - count record." Surveyor noted a table that included the following count times: "OFF 10PM-6:30AM, ON 6AM - 2:30PM, OFF 6AM - 2:30PM, ON 2PM - 10:30PM, OFF 2PM - 10:30PM, ON 10PM - 6:30AM." Surveyor</p>	N 409		

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N 409	<p>Continued From page 32</p> <p>noted there were no initials or other documentation to indicate a count or audit was completed on the following dates in March 2022: 3/1, 3/2, 3/3, 3/4, 3/7, 3/12, 3/14, 3/21, 3/27.</p> <p>On 3/30/2022 at approximately 3:15 PM, Surveyors interviewed Regional RN A who stated the medication passer leaving their shift and the medication passer starting their shift should be counting the narcotic (scheduled and PRN) medications and then initialing on the "Count Record" form. Surveyor stated the documentation of the daily narcotic count had multiple dates where there was no documentation to support the audit or count was completed for narcotic medications, including for PRN narcotic medications. Regional RN A verified the form did not always contain the information regarding the subtraction of medications when it is administered to a resident and that there was not an audit completed on the various dates that were blank on the March 2022 form.</p> <p>N0397 DHS 83.36(1)(b)2 Qualified Staff in Charge, On Duty and Awake N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet N0432 DHS 83.38(1)(h) Medication Administration</p>	N 409		
N 419	<p>83.37(3)(c) Medication storage: locked cabinet.</p> <p>Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all medications administered by</p>	N 419		

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N 419	<p>Continued From page 33</p> <p>the facility staff were locked at all times. Surveyors observed medications unlocked and unattended on the medication cart on 2 separate instances and unlocked on the nurse's station desk on 3 separate instances.</p> <p>Findings include:</p> <p>The facility is licensed to serve up to 55 residents who may be physically disabled, of advanced age, terminally ill, and/or have irreversible dementia/ Alzheimer's.</p> <p>On 03/29/2022 at approximately 8:15 AM, Surveyors entered the facility and immediately observed on the medication cart, 3 unmarked, disposable medication cups with pills/capsules in each of them and 1 bubble-packaged medication card of Risperidone 0.25 mg (an antipsychotic) on the nurse's station desk. The nurse's station was in the first room as one walks into the CBRF. There was a counter area with space behind the counter for staff but this was an area anyone would be able to walk through. Surveyors observed there were no staff in the vicinity of the nurse's station or medication cart for approximately 3 minutes while the medications were visible and unsecured. When 2 caregivers arrived to the nurse's station, they did not move the medications to a secure location. The nurse's station and medication cart were located directly off the dining room where approximately 7 residents were eating breakfast.</p> <p>On 03/29/2022 at approximately 8:30 AM, Surveyor observed Caregiver D complete a medication pass. Surveyor observed Caregiver D gave one of the unmarked cups of medications to Resident 1 who walked away with the medications still in the cup. Caregiver D said it</p>	N 419		

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N 419	<p>Continued From page 34</p> <p>was ok if Resident 1 took the medications to his/her room.</p> <p>On 03/29/2022 at approximately 10:00 AM, Surveyors observed 12 bubble-packaged medication cards on the nurse's station desk for Resident 2. Surveyors observed these medication cards were intermittently left unattended (as caregivers came and went from this location) and unlocked for approximately 2 hours until staff came to the nurse's station and handed Resident 2 the stack of medication cards to take to his/her room. At approximately 12 PM, Surveyors also observed the medication card of Risperidone that was on the nurse's station desk upon Surveyors' entry, was still on the nurse's station desk, unlocked and unattended.</p> <p>On 03/29/2022 at approximately 2:30 PM, Surveyors observed 3 bubble-packaged medication cards for 3 different residents on the medication cart behind the nurse's station desk, including Zoloft (an anti-depressant), Metoprolol and Risperidone (an antipsychotic). There were not any staff in the vicinity of the medication cart at the time Surveyors observed the medication cards for approximately 5 minutes. When 2 caregivers approached the nurse's station, neither caregiver moved the medication cards to a secured area and proceeded to walk away to complete other tasks, leaving the medications again unattended.</p> <p>On 03/30/2022 at approximately 3:15 PM, Surveyors interviewed Regional RN A who stated a new cycle of medications for the oncoming month had been delivered from the pharmacy and staff were checking them in throughout the day on 03/29/2022. Regional RN A verified the medications should have been stored in a locked</p>	N 419		

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N 419	Continued From page 35  location at all times when staff were not in the area.  N0409 DHS 83.37(1)(j) Proof of Use N0432 DHS 83.38(1)(h) Medication Administration	N 419		
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, record review, and interview, the provider did not ensure medications were administered appropriate to residents' needs. Medications were given to residents without observation of ingestion for 3 of 3 residents who were identified as requiring staff to administer medications. New medication orders for Resident 5 were not added to the MAR timely and subsequently were not administered as ordered.  Findings include:  The provider is licensed to serve up to 55 residents who may be physically disabled, of	N 432		

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N 432	<p>Continued From page 36</p> <p>advanced age, terminally ill, and/or have irreversible dementia/ Alzheimer's.</p> <p>On 07/05/2021, 07/20/2021, 11/09/2021, 12/09/2021, 04/10/2022, and 04/23/2022, the department received complaint information alleging concerns with medication administration including: staff administering medications without medication administration training, residents not getting medications as ordered, staff administering multiple residents medications at once, medication errors are happening frequently, and shifts being scheduled without staff who have been trained in medication administration.</p> <p>The CBRF is under the same roof as its sister RCAC (Residential Care Apartment Complex) facility. On 03/29/2022 at approximately 10:30 AM, Regional RN A verified that as a person enters the front door of the building, the RCAC tenant apartments are to the right, 1st and 2nd floor and the CBRF resident rooms are to the left, with general assisted living on the 1st floor and dementia/memory care, a secured unit on the 2nd floor through a set of closed doors. Regional RN A verified that all caregiver staff cover both the CBRF and RCAC every shift including medication administration. Regional RN A also verified some RCAC tenants eat meals in the dining room located on the 1st floor of the CBRF.</p> <p>On 03/29/2022 at approximately 8:15 AM, Surveyors arrived to the facility and observed 3 unmarked disposable medication cups with unidentified medications in them that were left unattended on the medication cart behind the nurse's station desk. Caregiver D was identified as the medication passer for the 1st floor CBRF residents and RCAC tenants. At approximately 8:30 AM, Surveyor began observing Caregiver D</p>	N 432		

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N 432	<p>Continued From page 37</p> <p>do the medication pass. Surveyor observed Caregiver D open the medication cart and fill a disposable cup with Miralax powder (a laxative) and put it next to the 3 unmarked medication cups. Caregiver D filled a disposable cup with water. Caregiver D then grabbed the cup with Miralax and 2 of the 3 unmarked medication cups and stacked them to hold the 3 cups in 1 hand and a cup of water in the other and bring them to the CBRF dining room where residents were eating breakfast.</p> <p>Surveyor observed Caregiver D put 1 of the cups of medications and a cup of water by RCAC Tenant 21, dropping 1 of the pills on the floor. Caregiver D then picked up the medication from the floor and put it back into the medication cup for Tenant 21 to take. Surveyor asked Caregiver D if s/he was going to give the pill that had been on the floor and Caregiver D said yes. Tenant 21 commented that the floor was dirty in which Caregiver D replied, "There's just Cheerios on it," and walked to another table with the other cups of medications in his/her hand leaving Tenant 21 with the medication still in the cup. A bystander resident of the CBRF observed the exchange between Caregiver D and the RCAC tenant with a grimace on his/her face.</p> <p>Caregiver D poured the Miralax powder into Resident 3's juice and put one of the cups of medications next to Resident 4. Resident 3 asked if Caregiver D could stir the powder in, which Caregiver D did upon request and then walked away without observing Resident 3 or Resident 4 ingesting the medications.</p> <p>Caregiver D then walked to the medication cart, grabbed a disposable cup, filled it with water, grabbed the 3rd unmarked medication cup and</p>	N 432		

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N 432	<p>Continued From page 38</p> <p>brought them to Resident 1's room. Caregiver D walked into Resident 1's room without knocking or acknowledging the resident, put the medication cup and cup of water on the table and walked out of the room without observing Resident 1 ingest the medications. Surveyor inquired if Resident 1 self-administers medications, in which Caregiver D stated "[Resident 1] does not like us to watch [him/her]. [S/he] was a nurse for many years and takes [his/her] medications after [s/he] eats." Surveyor then observed Caregiver D return to the nurse's station, take a drink of a beverage and go on his/her phone.</p> <p>Surveyor noted the medication cups with the pills had been set up but unattended for periods of time before Caregiver D began medication pass. There was no way for Caregiver D to know that someone didn't touch or move the pills or cups. There was no way to identify what medications were administered to Resident 1, Resident 4 or Tenant 21, and no way to know the medications were administered to the correct person (Resident 1, Resident 3, Resident 4, or Tenant 21).</p> <p>On 03/29/2022 at approximately 8:40 AM, Surveyor inquired with Caregiver D who s/he administered medications to in which s/he listed the resident's names (Resident 1, Tenant 21, Resident 3, and Resident 4). Surveyor inquired as to how s/he knew what medications were given and s/he stated from the MAR (Medication Administration Record). Surveyor noted Caregiver D did not reference a MAR, pill identifier or any form of documentation during the entire process of the medication pass. Surveyor requested to see the MAR in which Caregiver D proceeded to open up a program on the desktop computer located on the nurse's station desk.</p>	N 432		

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N 432	<p>Continued From page 39</p> <p>Surveyor observed Caregiver D click on resident's names and select "pass" and type in numbers very quickly. When done clicking and typing, Caregiver D stated to Surveyor the medications are listed on here and identified the color coding of when a medication is to be administered (green means it needs to be administered yet, white means it was already administered, etc.). Surveyor asked if s/he completed the documentation for the medication pass s/he just completed, and Caregiver D stated yes.</p> <p>On 03/29/2022, Surveyor reviewed Resident 1's Individualized Service Plan (ISP) most recent update on 11/15/2021 and noted the following related to medication administration: "[Resident 1] is unable to self-administer the following medication(s) (SPECIFY) r/t [related to] [statement end and no medications listed] ... [Resident 1] will receive medications safely and as prescribed ...Medications will be administered at the preferred time(s)(SPECIFY)[statement end and no medications listed] ...Medications will be administered by licensed or certified team members ...Medications will be administered with resident-preferred beverage (SPECIFY) [statement end and no preferences listed]."</p> <p>On 03/29/2022, Surveyor reviewed Resident 3's most recent ISP and noted "[Resident 3] is unable to self-administer prescribed medications r/t [related to] vision deficit ...[Resident 3] will receive medications as prescribed ...Licensed or certified team members will administer medications."</p> <p>On 03/29/2022, Surveyor reviewed Resident 4's most recent ISP and noted "[Resident 4] is unable to self-administer medications r/t [related to] memory loss ... Licensed/med delegated staff will</p>	N 432		
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N 432	<p>Continued From page 40</p> <p>administer medications as prescribed."</p> <p>On 03/29/2022, Surveyor also noted in Resident 1, Resident 3, and Resident 4's records, physician orders that stated: "Does the resident lack the physical or mental capacity to self-administer his/her own medications?... IF YES: I authorize CBRF staff, who have met the requirements of HFS 83 for medication administration, to administer medications as prescribed to the resident. Staff positions may include Director of Operations, Director of Housing, Area Manager, CNA Resident Assistant, and others in certain circumstances, including Activity Coordinator, Cook/Dietary, Administrative Clerk, and Housekeeping," with "YES" checked for both questions for all 3 resident records.</p> <p>On 03/30/2022 at approximately 3:30 PM, Surveyors interviewed Regional RN A and Regional Director C who verified the medication administration process was not followed, Resident 1, Resident 3, and Resident 4 did not receive their medications based on their needs, and none of the 3 residents should be self-administering their medications per physician orders.</p> <p>Surveyor note: According to the National Library of Medicine, comfort measures is a care plan that includes physician orders that address patient's potential bodily symptoms of discomfort that may be implemented when curative treatment has been stopped and death is expected. Source: <a href="https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8740772/#:~:text=Comfort%20Measures%20Only%20(CMO)%20is%20a%20care%20plan%20that%20includes,stopped%20and%20death%20is%20expected">https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8740772/#:~:text=Comfort%20Measures%20Only%20(CMO)%20is%20a%20care%20plan%20that%20includes,stopped%20and%20death%20is%20expected</a>. Retrieved 05/04/2022 3:40 PM</p> <p>On 04/04/2022, Resident 5 was evaluated as</p>	N 432		

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N 432	<p>Continued From page 41</p> <p>being at end of life. Resident 5's physician ordered comfort measures to be initiated and to discontinue any medications that were not strictly for comfort use. On 04/26/2022 at approximately 2:15 PM, Surveyor interviewed Resident 5's Hospice RN M who stated, generally s/he does not request morphine and lorazepam to be scheduled and leaves it to facility staff to assess the resident for discomfort and administer as needed on a set timeframe (example - administer morphine every 4 hours as needed for signs of pain or shortness of breath), but RN M felt s/he had to get the morphine and lorazepam scheduled so staff would have to follow a schedule in the MAR. Hospice RN M stated staff at this facility "seem to consider as needed [PRN] medications as out of sight, out of mind and don't think to administer unless there are specific scheduled orders." Hospice RN M stated, on 04/04/2022, Resident 5 was prescribed morphine every 4 hours and lorazepam to be crushed and given every 4 hours for comfort.</p> <p>On 04/28/2022, Surveyor reviewed Resident 5's hospice record which verified on 04/04/2022, Resident 5 had written scheduled orders for morphine and lorazepam to be administered every 4 hours to keep resident comfortable at end of life. Surveyor compared the written order to Resident 5's April 2022 MAR and medication list from the provider and noted that the MAR was not changed. The MAR noted morphine and lorazepam PRN. Surveyor noted Resident 5 received morphine and lorazepam on 04/04/2022 at 7:00 PM and then not again until 04/05/2022 at 6:30 AM despite the every 4 hour documented order.</p> <p>On 04/26/2022 at approximately 2:15 PM, Hospice RN M shared that Resident 5's family</p>	N 432		

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N 432	<p>Continued From page 42</p> <p>informed him/her that Resident 5 did not appear as comfortable as s/he could have been overnight, but there was not any staff working who were trained to administer the morphine and lorazepam. Hospice RN M reiterated that the facility did not schedule a medication passer on night shift on 04/04/2022 or 04/05/2022 to pass medications despite Resident 5's scheduled comfort medications. (Cross Reference: N0397 Qualified Staff) Hospice RN M stated s/he had conversations with RN Director L on the orders multiple times as the family reported to him/her that they had to actively request for staff to administer the comfort medications even though they were ordered on a schedule. Hospice RN M mentioned the provider did not initially have access to Bluestone Physicians software, which is where the physician notes and orders would be sourced from. Resident 5 passed away on 04/06/2022. Hospice RN M stated s/he was notified after Resident 5's death that RN Director L added the scheduled morphine and lorazepam orders added to the MAR. Hospice RN M indicated family felt they had to stay at Resident 5's bedside 24/7 after s/he started to decline in condition to ensure staff were keeping him/her comfortable and administering medications.</p> <p>On 04/26/2022 at approximately 1:00 PM, Surveyor interviewed RN Director L who verified a trained medication passer was not scheduled on night shift on 04/04/2022 or 04/05/2022 who would be able to administer or assess effectiveness of Resident 5's comfort medications as ordered.</p> <p>RN Director L verified the scheduled morphine and lorazepam orders were not in their system prior to or at the time of Resident 5's passing.</p> <p>In conclusion, Resident 1, Resident 3, Resident</p>	N 432		

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N 432	Continued From page 43  4, and Resident 5 did not receive medications meant to be administered by provider staff as prescribed or appropriate to their needs.  N0214 DHS 83.15(3)(a) Supervisor Shall Supervise Daily Operation N2349 DHS 83.20(2)(d) Department Approved Training Courses N0348 DHS 83.32(3)(e) Rights of Residents: Free from Mistreatment N0397 DHS 83.36(1)(b) 2 Qualified Staff in Charge, On Duty and Awake N0409 DHS 83.37(1)(j) Proof of Use Record N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet	N 432		
N 504	83.46(1)(c) Heating system maintenance.  Heating. The CBRF shall maintain the heating system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2.  This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the gas furnaces were serviced at least once every 3 years. There was no documentation the furnaces had been	N 504		

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N 504	<p>Continued From page 44</p> <p>inspected.</p> <p>Findings include:</p> <p>The facility is licensed to provide services for up to 55 residents who may be terminally ill, advanced aged, physically disabled, and/or have Alzheimer's/dementia.</p> <p>On 03/29/2022, Surveyors toured the facility and observed more than 4 gas furnaces throughout the facility.</p> <p>On 03/29/2022 at approximately 2:00 PM, Surveyors interviewed Regional Support Manager B who stated s/he was unable to locate any documentation of inspections for the gas furnaces and the Maintenance Director who would have completed the inspections is no longer an employee at the facility.</p> <p>On 03/30/2022 at approximately 2:30 PM, Surveyors interviewed Regional Nurse A and Regional Director C who verified the provider was unable to provide documentation or confirmation that inspections of the furnaces were completed in the past 3 years.</p>	N 504		
Y3244	<p>50.09(1)(L) Care</p> <p>(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</p> <p>(l) Receive adequate and appropriate care within the capacity of the facility.</p>	Y3244		

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Y3244	<p>Continued From page 45</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the provider did not ensure residents received appropriate care within the capacity of the facility for at least 14 residents identified (Resident 1, Resident 5, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, Resident 16, Resident 17, Resident 18, Resident 19 and Resident 20).</p> <p>Findings include:</p> <p>The facility is licensed to provide services for up to 55 residents who may be advanced aged, terminally ill, physically disabled and/or have Alzheimer's/dementia.</p> <p>On 02/26/2021, 06/07/2021, 07/05/2021, 07/16/2021, 07/20/2021, 11/09/2021, 12/09/2021, 04/10/2022, 04/22/2022, 04/23/2022, 04/24/2022, and 04/26/2022 the department received complaint information alleging lack of appropriate care for residents at the facility including several specific complaints regarding assistance with toileting and changing when wet/soiled, assistance with repositioning and showering.</p> <p>On 03/29/2022 at approximately 9 AM, Surveyor interviewed Caregiver I. When asked how things were going at the facility, Caregiver I stated, "Bad! There's not enough staff and we've</p>	Y3244		

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Y3244	<p>Continued From page 46</p> <p>reported resident neglect [to management] and nobody does anything..." Caregiver I specifically stated Caregiver E does not change residents' protective undergarments through the night shift. "The night before (03/27/2022) [s/he] left [Resident 5] wet up to [his/her] neck. Three [staff] noticed, [Caregiver G and Caregiver H] can tell you." (Surveyor spoke to Caregiver H on 03/28/2022 at approximately 12 PM and Caregiver H did confirm this information.) Caregiver I informed Surveyor that on memory care (2nd floor CBRF), all residents are supposed to be checked every 2 hours for incontinence during night shift and on the first floor CBRF, there are 5 residents (Resident 1, Resident 9, Resident 10, Resident 11 and Resident 12) that are to be checked for incontinence every 2 hours and assist as needed. When Caregiver E works, his/her residents are saturated in the morning. "[Resident 1] can be rude so [Caregiver E] refuses to take care of [him/her] at all even when [s/he's] assigned."</p> <p>On 03/29/2022, Surveyor reviewed Resident 5's most recent Individual Service Plan (ISP) which noted, "[Resident 5] has bladder incontinence. ... Assist [Resident 5] to the bathroom as per preference and/or per [Resident 5's] individualized routine. ...BRIEF USE: disposable briefs. Change approximately every 2-3 hours and as needed. ...Encourage and assist [Resident 5] with cleansing perineal area after each incontinence episode. ...[Resident 5] will remain free from skin breakdown due to incontinence and brief use. ... [Resident 5] has potential impairment to skin integrity r/t [related to] bladder incontinence, decreased mobility. ... dementia...Anticipate resident's needs:...toileting needs..."</p>	Y3244		

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Y3244	<p>Continued From page 47</p> <p>On 03/29/2022, Surveyor reviewed Resident 1's most recent ISP which noted, "[Resident 1] has bladder incontinence r/t urge incontinence, Nocturia [frequent nighttime urination]... Staff will assist resident with cleansing perineal area after each incontinence episode. Staff will change brief every 2 hours and as needed by utilizing Hoyer lift and two staff members. ...[Resident 1] has potential impairment to skin integrity r/t limited mobility... Staff will observe skin. Keep skin clean and dry. ..."</p> <p>On 03/29/2022 at approximately 9:30 AM, Surveyor interviewed Caregiver D who stated, "Most of the people who were neglectful no longer work here except [Caregiver E]."</p> <p>On 03/29/2022 at approximately 11:15 AM, Surveyor interviewed Caregiver F (who worked memory care unit). When asked how things were going at the facility, Caregiver F stated, "We're understaffed, there is definitely a lack of cares. ... I had off the weekend. When I came in on Monday [03/28/2022] [Resident 13] had on the same shirt as when I left Friday [03/25/2022] and [his/her] sheet was half off the bed." (Surveyor reviewed the work scheduled and the days Caregiver F referenced matched her scheduled/unscheduled work dates.) Caregiver F stated, "You can tell they haven't been checked on 3rd shift. Their brief [protective undergarment] is saturated and yellow-orange. The residents you can tell are the most un-cared for are [Resident 14 and Resident 13]." Caregiver F went on to comment that 2nd shift cares have been good. On 1st shift there are 3-4 staff but cares still don't always get done. There's no charting that some showers are getting done so it seems like there are residents who aren't showered. Two hour toileting doesn't always</p>	Y3244		
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Y3244	<p>Continued From page 48</p> <p>happen.</p> <p>On 03/29/2022, Surveyor reviewed Resident 14's ISP which noted, "One staff member will assist with toileting as needed. Staff will utilize sit to stand lift by 1 staff member to transfer between surfaces daily and as necessary...Initiated 09/02/2021"</p> <p>On 03/29/2022 at approximately 12 PM, Surveyor interviewed Caregiver H (who worked memory care unit). Caregiver H commented when s/he comes on shift in the morning, some residents "have beyond soaking wet Depends [protective undergarments] and sometimes no sheets on the beds. [Caregiver E] is the main one." Caregiver H named Resident 5, Resident 18 who is "always super soaked," and sometimes Resident 15 and Resident 19. Resident 18 is sometimes still in his/her clothes from the day before. Caregiver H commented that sometimes Resident 20 is wet too but "[s/he] wakes up and wanders so there's no reason not to change [him/her].</p> <p>Surveyor reviewed Resident 18's ISP which noted, [Resident 18] has bladder incontinence r/t diagnoses...[Resident 18] will remain free from skin breakdown due to incontinence and brief use...Assist [Resident 18] to the bathroom as per preference and/or per [his/her] individualized routine. ...Encourage and assist [Resident 18] with cleansing perineal area after each incontinence episode."</p> <p>On 03/29/2022 at approximately 11:30 AM, Surveyor interviewed Caregiver G (who worked memory care unit). Caregiver G commented 3rd shift is a problem. When Caregiver G comes in at the beginning of 1st shift there are several residents who are so wet they need a full bed</p>	Y3244		

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Y3244	<p>Continued From page 49</p> <p>change done. Consistently Resident 5, Resident 15, Resident 16 and Resident 17 are soaked in the morning and obviously weren't checked on every 2 hours. When asked who is working when residents aren't changed, Caregiver G replied [Caregiver E] and/or agency staff and "it's been happening almost since I started, actually since [Caregiver E] started." (Caregiver E's date of hire, 02/24/2021.) Caregiver G said staff told the old director about [Caregiver E] but there was no change.</p> <p>Surveyor reviewed Resident 15's ISP which noted, "[Resident 15] has a history of bladder incontinence r/t diagnoses... [Resident 15] will remain free from skin breakdown due to incontinence and brief use...BRIEF USE: (SPECIFY size and type) disposable briefs. Change (SPECIFY FREQ) and as needed. Encourage and assist resident with cleansing perineal area after each incontinence episode. Encourage the resident to request assistance as needed with ambulation to the bathroom."</p> <p>Surveyor reviewed Resident 16's ISP which noted, "[Resident 16] is independent in toileting. ...Any changes will be reported to the nurse."</p> <p>Surveyor reviewed Resident 17's facesheet which noted, "Diagnosis: ...Nocturia [frequent nighttime urination]..." and ISP which noted: "Resident had a self care performance in toileting r/t [related to] poor mobility, memory loss, and chronic pain...BRIEF USE: 2XL disposable briefs. Change, toilet and provide peri-care every two hours and PRN (as needed)... -initiated 03/17/2022 (no revision) Resident has bowel incontinence r/t memory loss, poor mobility, chronic pain. The resident will be continent during daytime. Assist resident with</p>	Y3244		

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Y3244	<p>Continued From page 50</p> <p>toileting per resident preference and frequently due to skin breakdown. Provide assistance per resident preference with perineal care and offer use of continence products during episodes of incontinence. -revision 03/22/2022</p> <p>Resident will receive assistance with toileting...BATHROOM ASSISTANCE: Encourage resident to participate as much as possible to promote independence. The resident needs assistance from one of care team members for toilet use. -revision 03/22/2022</p> <p>The resident has potential/actual impairment to coccyx, sacral, and buttock areas. ... Observe skin. Keep skin clean and dry. Hydrate skin with lotion, as needed. Specify and areas that should not have lotion applied. Report any skin alterations to nurse. Provide resident with pressure relieving devices (air mattress, hospital bed) as ordered by MD to protect skin integrity. Weekly treatment documentation to include measurement of each area(s) of skin breakdown: width, length, depth; type of tissue and exudate; and any other notable changes or observation. Report improvements and declines to the MD-managed by SN. -Date initiated 03/22/2022."</p> <p>Based on Resident 17's "actual impairment to coccyx, sacral, and buttocks areas," and complaints specific to Resident 17's lack of care resulting in significant skin breakdown and admission to hospice services, Surveyors conducted additional interviews and record review:</p> <p>Resident 17 (continued): (Cross Reference N0348 Rights of Residents: Free from Mistreatment)</p> <p>Resident 17 was admitted to the facility on 03/02/2022 with diagnoses to include dementia, sleep disorder, nocturia. Physician note from</p>	Y3244		

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Y3244	<p>Continued From page 51</p> <p>01/19/2022 (prior to admission) notes Resident 1 urinates approximately 10 times through the night.</p> <p>On 05/02/2022 at approximately 4:15 PM Surveyor obtained written interview information with Resident 17's Family P. Family P reported that Resident 17 was admitted to the facility on 03/02/2022. On 03/09/2022 Family gave Resident 17 a cell phone. On that same date, Resident 17 called various family members approximately 5 times stating that s/he pushed the call button multiple times but no one came to help therefore requested family to come to the facility to help him/her use the bathroom. Family called the unit on that date and reported that Resident 17 keeps calling family to take him/her to the bathroom because no staff will help when s/he pushes the button. This continued everyday until 03/15/2022. On 03/15/2022, Family P was at the facility and pressed the call button for Resident 17 to get assistance to use the bathroom and again, nobody came. Family P went to the desk to get caregiver assistance and when done with the bathroom, Family P requested the caregiver test Resident 17's call button. It was discovered that the call button had not been working, so for approximately 13 days Resident 17 was unable to reach any caregiver in the manner s/he was told to request assistance and therefore had been forced to be incontinent much of the time. Family P stated, "That is why [Resident 17] keeps calling [his/her] [family members] to come help [him/her]. [S/he] couldn't go to the bathroom and sits and lays in [his/her] urine." Family P stated Resident 17 had his/her first shower on 03/25/2022 (23 days after admission). On 03/29/2022 Family P discovered the staff had taken Resident 17's call button away from him/her when s/he was at the hospital</p>	Y3244		

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Y3244	<p>Continued From page 52</p> <p>(03/18/2022) because s/he kept pushing the button so they took it away from him/her. Regional RN A informed Family P that s/he had been unaware staff had taken the call button from Resident 17 and Regional RN A gave it back on 03/30/2022. Family P verified there were more times than could be counted that Resident 17 was wet in his/her own urine and no way to know how long but beyond the point of saturation. Resident 17 came to the facility on 03/02 with skin intact and by 03/14/2022 Resident 17 informed staff of an open wound on his/her coccyx (staff did not discover this, Resident informed staff). Resident 17 ended up developing numerous and severe open and infected skin wounds which resulted in severe infection, placed on hospice and the family moved Resident 17 from the facility on 04/18/2022.</p> <p>On 05/03/2022 at approximately 9:45 AM Surveyor obtained written interview information with Resident 17's Family Q. Family Q reported, "[Resident 17] was neglected daily. ...no one was checking on [him/her] through the night and especially on weekends." Family Q reported, "For the first 2 weeks the call button didn't even work and yet the staff never bothered to check it. [S/he] was also placed in [his/her] wheelchair for hours where[s/he] sat in [his/her] own urine without ever being changed. Oak Park was notified that [Resident 17] needed to be repositioned every 2 hours but that wasn't happening. Unfortunately, the neglect continued. They finally replaced the call button, but it was taken away because staff said [s/he] pressed it too often. ... [Resident 17] was still left sitting in [his/her] own urine until [his/her] wounds became worse and infected. ...[Resident 17] became bedridden and needed a 2 person assist with a</p>	Y3244		
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Y3244	<p>Continued From page 53</p> <p>Hoyer, but [they] did not use this. Instead [Resident 17] was left to sit in [his/her] urine even longer than before. [Resident 17] became weaker, and the staff would set [his/her] tray of food in front of [him/her] with covers and plastic, and [s/he] was not able to open them. Also [Resident 17] was not propped up, so [s/he] couldn't eat anyway. ... [Resident 17] was reported to be malnourished in the ER. ... [Resident 17's] [spouse and family] are devastated at the lack of care that was given."</p> <p>On 04/28/2022 at approximately 4 PM Surveyor interviewed Home Health Nurse N who discussed that Resident 17 had skin issues in his/her history but when admitted to the facility on 03/02/2022 Resident 17's bottom, feet, heels all looked great without redness or open areas. One month after admission (on 04/02/2022), Resident 17 was re-admitted to home health services due to wounds that developed after admission to the facility which required wound care. At the facility, when Nurse N attempted to find staff to ask for help, it was very hard to find someone because staff didn't answer call lights and Nurse N had to leave Resident 17 to go physically find a caregiver causing Resident 17 to have to wait. By Nurse N's 2nd visit to the facility, there was no nurse to give directions to so s/he gave simple directions, "Make sure coccyx is dry at all times, if not, change it to a new dry bandage. If the bandages came off, all we wanted was for staff to put a new bandage back on and call home care and a nurse will come in to treat the wound. Every time we went [to Resident 17] the bandaging was soaked on the tailbone; [s/he] was soaked!" Nurse N commented that his/her last 2 visits at the facility, Resident 17 was soaked in urine through the Hoyer sling. Nurse N explained Resident 17's wound treatment was</p>	Y3244		
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Y3244	<p>Continued From page 54</p> <p>transitioned from home health to hospice and s/he let hospice know there were struggles in the facility with the cares for Resident 17.</p> <p>On 04/28/2022 at approximately 3:30 PM Surveyor interviewed Hospice Nurse O who commented s/he was not surprised if there were concerns from families or others about the care provided at the facility. Nurse O stated s/he additionally cares for 2 other residents at this facility and confirmed that it had been "very difficult to find anyone or get ahold of anyone that works there." Nurse O further verified Resident 17 developed his/her wounds due to "lack of repositioning and providing appropriate cares."</p> <p>On 03/29/2022 at approximately 11:15 AM, Surveyor interviewed Caregiver F who discussed lack of resident care by the co-workers and further commented, "No one tells us anything like what the cares are supposed to be. No one has trained me on how to access the ISP [Individual Service Plan]." At approximately 12 PM, Surveyor interviewed Caregiver H who commented, "I have no idea about ISPs, we just go off what people tell us for services. Communication sucks here. Sometimes we don't even know there's a new resident until we see them and we have no idea about cares. On 05/12/2022 at approximately 8 AM, Surveyors interviewed Regional RN L who stated the ISP drives the care for the residents, but there is also a document called the "Care Card" which is a simplified version. It is a tool kept on the unit that staff reference to know what cares to provide to each resident. On 05/12/2022, Surveyors requested a copy of Resident 17's Care Card. At 10:20 AM, Regional Support Manager B stated, "We were not able to find a care card for [Resident 17]."</p>	Y3244		

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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
Y3244	<p>Continued From page 55</p> <p>On 04/29/2022 and 05/03/2022, Surveyor inquired with Regional Support Manager B and Regional RN L regarding documentation for resident treatments and monitoring of staff completing resident tasks. Surveyor received no response to either inquiry. As of 05/12/2022, there was no evidence to support any monitoring of treatment and cares provided to residents who were being monitored.</p> <p>In summary: There were at least 14 residents identified (Resident 1, Resident 5, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, Resident 16, Resident 17, Resident 18, Resident 19 and Resident 20) who had not received care as identified in the residents' ISPs and which was within the capacity of the facility.</p> <p>Cross Reference: N0214 83.15(3)(a) Administrator Shall Supervise Daily Operation N0348 83.32(3)(d) Rights of Residents: Free from Mistreatment N0397 83.36(1)(b) Qualified Staff in Charge, On Duty and Awake</p>	Y3244		