

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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NAME OF PROVIDER OR SUPPLIER CARE PARTNERS STEVENS POINT 1	STREET ADDRESS, CITY, STATE, ZIP CODE 3349 BUILDING A WHITING AVENUE STEVENS POINT, WI 54481
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{N 000}	<p>Initial Comments</p> <p>On 08/03/2023 and 08/07/2023 Surveyor conducted onsite visits at Care Partners Stevens Point 1 to investigate a complaint, a self-report, complete a survey and conduct a verification visit. Additional information was received through 08/16/2023. The previous 4 deficiencies were corrected, the complaint was substantiated and 8 new deficiencies were identified.</p> <p>Census: 13</p> <p>Under statutory provisions of WI Stat. Ch. 50 a \$200 revisit fee is being assessed.</p>	{N 000}		
N 158	<p>83.12(2)(a) Caregiver: Investigating abuse & neglect</p> <p>Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.</p>	N 158		

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

TITLE

(X6) DATE

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N 158	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review and interview, after receiving an allegation of abuse, the provider did not take steps to immediately protect the safety of all residents or conduct a thorough investigation into the allegations to determine if misconduct occurred that required reporting to the department within 7 days.</p> <p>Beginning in October 2022, the provider received complaints from residents, including Resident 1, that Caregiver B used a loud and disrespectful tone and was rough during cares. In addition, Resident 1 specifically alleged Caregiver B refused to provide necessary transfer assistance during 3rd shift. Administrator A did not take steps to protect the safety of residents or document investigations into the allegations to determine if verbal abuse or neglect occurred that warranted misconduct reporting to the Office of Caregiver Quality (OCQ). Caregiver B continued his/her employment at the facility.</p> <p>On 04/11/2023, at the start of 3rd shift, Assistant Administrator C was informed Caregiver B forcibly took Resident 1's cell phone from him/her to prevent Resident 1 from calling 911 to request medical evaluation. Assistant Administrator C did not immediately report the allegations of misconduct to Administrator A to investigate and Caregiver B worked the remainder of 3rd shift providing care to other residents. Resident 1's request for medical evaluation was not honored until the following afternoon when s/he was diagnosed with a urinary tract infection (UTI) and had his/her catheter tubing replaced. Administrator A did not initiate an investigation until 11-12 hours after the allegations were first known. Administrator A substantiated abuse and terminated Caregiver B but the provider did not</p>	N 158		

Wisconsin Department of Health Services

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N 158	<p>Continued From page 2</p> <p>report the incident to OCQ on the form provided by the department within 7 days from the date the CBRF knew about the abuse.</p> <p>During the aforementioned investigation of the 04/11/2023 incident, Administrator A received allegations of abuse against a second caregiver; Resident 1 alleged to at least 2 staff members that Caregiver D pulled on his/her catheter causing pain/bleeding and prompting his/her request for medical evaluation on 04/11/2023. Administrator A did not thoroughly investigate the allegations to determine if the incident warranted misconduct reporting to OCQ.</p> <p>This is a repeat deficiency being cited for the 2nd time. See Statement of Deficiency 5MV212, dated 02/25/2021.</p> <p>Findings include:</p> <p>The department received a complaint regarding caregiver misappropriation and indicated management was aware of the incidents of misappropriation but did nothing about it.</p> <p>On 04/17/2023, the department received a self-report from the provider which documented allegations of misconduct against Caregiver B and Caregiver D which occurred on 04/11/2023.</p> <p>SELF-REPORT - On 08/03/2023, Surveyor reviewed the facility's self-report related to the 04/11/2023 incident. The self-report included the following documents:</p> <p>Investigation summary dated 04/13/2023 authored by Administrator A: 04/11 at 11:00 PM Resident 1 was "complaining of pain in [his/her] groin area...complaining of</p>	N 158		

Wisconsin Department of Health Services

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N 158	<p>Continued From page 3</p> <p>burning...and wanting to call 911 to get some help." Caregiver B told Resident 1 s/he needed to wait for day shift. Resident 1 told Caregiver B s/he would call 911. Caregiver B "took [Resident 1's] phone and stated [s/he] couldn't call 911."</p> <p>Caregiver B called Assistant Administrator C during the incident. Administrator A told Caregiver B s/he was violating Resident 1's rights and instructed him/her to give the phone back. Assistant Administrator C reported to the facility at midnight. Resident 1 told Assistant Administrator C "[s/he] was assaulted and [Caregiver B] physically jumped on [him/her] to grab [his/her] phone."</p> <p>Administrator A was notified of the incident at 04/12 (time not documented) 04/12 "[Resident 1] was very vocal on how [s/he] was treated and went into [his/her] room to call [police] to make a complaint." 04/12 during the afternoon Resident 1 was sent to the emergency room (ER) and "received a new cath (catheter) and...has a UTI" Caregiver B is "very loud and swearing at resident, [s/he] has already been talked to regarding [his/her] tone and regarding resident rights." "Refusing to get [Resident 1] up when [s/he] is asking to...Resident stated that [Caregiver B] is refusing to get resident up that it's not [his/her] job" (additional context about this was not documented) "I have suspended [Caregiver B] till [sic] investigation is completed."</p> <p>Incident Report authored by Assistant Administrator C on 04/12: "04/11...received phone call from [Caregiver B] stating...resident was upset because other staff [Caregiver D] had...accidentally bumped</p>	N 158		

Wisconsin Department of Health Services

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N 158	<p>Continued From page 4</p> <p>[Resident 1]'s right leg with the catheter and somehow thought it ended up yanking the catheter. Because of this [Resident 1] decided [s/he] wanted to go to the ER."</p> <p>Caregiver E written statement: On 04/12 at 5:30 PM, Resident 1 alleged the previous night, "[Caregiver D] was pulling on [his/her] catheter to the point where [s/he] was bleeding from [his/her genitals]." Resident 1 said s/he told Caregiver D to stop but Caregiver D grabbed the leg with the tubing attached and said, "I'm a CNA (certified nursing assistant) I know what I'm doing." Resident 1 told Caregiver E s/he thought Caregiver D "was going to rip [his/her genitals] off because [s/he] was so rough...."</p> <p>Caregiver F written statement: On 04/12 during 2nd shift Resident 1 alleged the previous night "[Caregiver D] pulled [his/her] leg...that had the catheter hose and injured [his/her genitals] and it began to bleed..."</p> <p>Document dated 04/14/2023 signed by Administrator A: "Regarding [Caregiver D] [S/he] leans over [his/her] leg with catheter to adjust other leg and [his/her stomach] touch [sic] the leg with the catheter. [S/he] did not pull on catheter." . This was the entirety of the document, and it did not detail the investigative steps taken to reach the conclusion. The document did not include the time, date, place, individuals involved or details of the occurrence or the action taken by the provider to ensure residents' health, safety and well-being. (source: DHS 83.12(6)).</p> <p>Surveyor noted: Administrator A's investigation summary dated 04/12/2023, did not include</p>	N 158		

Wisconsin Department of Health Services

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N 158	<p>Continued From page 5</p> <p>information about the immediate steps taken to protect Resident 1 and all the other residents for the remainder of 3rd shift 04/11-04/12/2023 . It also did not document an investigation into allegations received 04/12/2023 against a second caregiver (Caregiver D). In addition, review of Department records indicated the provider did not submit a misconduct incident report (the form provided by the Department) for Caregiver B to the Office of Caregiver Quality.</p> <p>INTERVIEWS - Surveyor conducted the following interviews on 08/03/2023: Resident 1 at 1:09 PM, Assistant Administrator C at 1:40 PM and Administrator A at 2:09 PM.</p> <p>RESIDENT 1 stated: On 04/11 Caregiver B jumped completely on top of him/her while Resident 1 was laying in bed and took away his/her cell phone. In addition, Caregiver D grabbed his/her leg with the catheter tubing attached and "it felt like [s/he] pulled the tube out...I was uncomfortable all night." S/he experienced problems with Caregiver B refusing him/her care for months before this incident. Resident 1 explained s/he relies on staff assistance with transfers, suffers from pain and uses a bed pan at night. During the night s/he would call for help transferring out of bed because it was hard to use the bed pan and sometimes because s/he was in pain and wanted to change position by getting out of bed. Caregiver B would say, "I'm not getting you up. You're staying in bed. I'm not playing this up and down game with you." Resident 1 said this happened almost daily and s/he reported the concerns to Administrator A. Caregiver B is not the only 3rd shift staff who denied his/her requests for transfer assistance</p>	N 158		
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N 158	<p>Continued From page 6</p> <p>and the problem is ongoing.</p> <p>Resident 1 described other staff related concerns and said, "I tell [Administrator A], s/he does nothing (and says) it's hard to prove who does it." Resident 1 said s/he's stopped reporting because "I feel it doesn't do any good, so why do it."</p> <p>ASSISTANT ADMINISTRATOR C stated: On 04/11 just before 12:00 AM s/he received a call from Caregiver B who admitted s/he had taken Resident 1's cell phone away to prevent him/her from calling 911. When s/he received the call from Caregiver B, s/he was already en route to work 12:00 AM - 2:00 PM.</p> <p>Upon arrival s/he calmed Resident 1 down and talked him/her out of going to the emergency room to avoid calling and waking his/her POA (power of attorney) to get permission to go to the ER.</p> <p>Resident 1 also reported concerns about Caregiver D and said s/he bumped his/her leg and caused pain at the catheter insertion site. Caregiver B and Caregiver D worked for the remainder of 3rd shift caring for all residents except Resident 1. Assistant Administrator C spent most of 3rd shift in the office completing paperwork, but would answer Resident 1's call light.</p> <p>Note: Surveyor observed the office is in the very front of the building and not in close proximity to most resident rooms, including Resident 1's room. In addition, according to Stevens Point Police Report C23-03550, Caregiver B stated Caregiver D responded to Resident 1's call light and provided cares the remainder of the night. Approximately 10:00 AM on 04/12, Resident 1 again requested to be medically assessed at the ER. Assistant Administrator C observed blood in his/her urine bag and called his/her POA. While on the phone, the police showed up because</p>	N 158		

Wisconsin Department of Health Services

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N 158	<p>Continued From page 7</p> <p>Resident 1 called them. Approximately 10:00 AM on 04/12 (11-12 hours after the incident) s/he first reported the allegations of abuse to Administrator A. From the time Caregiver B was hired in October 2022, residents complained about his/her tone, volume and demeanor. Resident 1 specifically complained Caregiver B was loud, argumentative, rough during cares and would refuse to get him/her up during the night. Assistant Administrator C said s/he talked to Caregiver B who would either say Resident 1 refused to get up or it was 1st shift's job. S/he did not document the concerns or his/her discussions with Caregiver B and did not recall reporting the allegations to Administrator A to investigate.</p> <p>ADMINISTRATOR A stated: S/he could not recall and did not document what time Assistant Administrator C first informed him/her of the abuse allegations on 04/12, but said 10:00 AM sounded right.</p> <p>On 04/12 s/he interviewed Resident 1 who was "so upset" and alleged Caregiver B "jumped on me and ripped my phone out of my hand." Caregiver B's employment was terminated as a result of the incident.</p> <p>In the months preceding the incident Resident 1 complained to Administrator A that Caregiver B would refuse to help him/her out of bed during the night. Administrator A warned Caregiver B this was against Resident 1's rights. Administrator A was aware Caregiver B continued to refuse Resident 1's requests even after the warning. The only documented response to concerns about Caregiver B was a written warning on 11/25/2022 when management observed him/her sleeping during 3rd shift.</p> <p>On 04/12 Resident 1 also alleged Caregiver D caused pain at the catheter insertion site during</p>	N 158		

Wisconsin Department of Health Services

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N 158	<p>Continued From page 8</p> <p>cares on 04/11. S/he responded by talking to Caregiver D but did not remember or document the date/time. Caregiver D denied the allegations and said s/he just bumped the catheter tubing while leaning over Resident 1. Caregiver D quit right after the incident for fear of losing his/her CNA license.</p> <p>S/he did not further investigate the allegations against Caregiver D by interviewing other residents who may have heard or witnessed the incident. S/he did not interview other residents or other staff to determine if they had concerns about Caregiver D's treatment of residents. Based on only Caregiver D's denial, s/he unsubstantiated Resident 1's allegations. Caregiver D worked 3rd shift 04/12/2023 and then quit.</p> <p>S/he did not complete other documentation related to the 04/11 investigation other than what was submitted as part of the self-report. Per their policy, s/he is responsible to initiate caregiver misconduct investigations, and provided Surveyor a copy of the policy. Administrator A submits his/her investigation to the corporate office and Director M is responsible for reporting to the Department.</p> <p>RECORD REVIEW - On 08/07/2023, Surveyor reviewed the current "ABUSE/MISCONDUCT POLICY" and Resident 1's complete facility record.</p> <p>The policy read in part, "...All employees...are required to immediately report any known or suspected resident abuse to the Director (Administrator)...When allegations involve the possible commission of a crime, reporters should also separately notify law enforcement...In the event of physical abuse, the resident shall be examined by the attending physician to determine</p>	N 158		
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N 158	<p>Continued From page 9</p> <p>the extent and nature of any injuries...Upon learning of an incident of alleged misconduct, the Director shall take whatever steps are necessary to ensure that resident(s) are protected from subsequent episodes of misconduct while a determination on the matter is pending...'Abuse' means any of the following, if done intentionally: A. An act, omission or course of conduct by another that is not part of a treatment plan...and does any of the following: 1. Results in physical pain or injury, illness...2. Intimidates, humiliates, threatens, frightens, or otherwise harasses a resident. 3. Substantially disregards a resident's rights...or a caregiver's duties and obligations to the resident..."</p> <p>Resident 1's medical history was significant for urinary retention, catheter, edema, left side paralysis due to stroke and anxiety. Resident 1 was his/her own legal decision maker and did not have an activated power of attorney for health care. The individual service plan read, "Is able to self propel in wheelchair, needs assist of one with transfers to toilet, bed and wheelchair... Can make needs known. Call light and pull cord when needing help."</p> <p>Cross Reference: N0230 DHS 83.19 Orientation N0277 DHS 83.25 Continuing Education N0348 DHS 83.32(3)(d) Rights of Residents: Free from Mistreatment</p>	N 158		
N 161	<p>83.12(3)(a) Investigate injuries of unknown source.</p> <p>Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The</p>	N 161		

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N 161	<p>Continued From page 10</p> <p>source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident.</p> <p>This Rule is not met as evidenced by: Based on observation and record review, the provider did not investigate the source of an injury to a resident that could not be adequately explained by the resident (Resident 2).</p> <p>On 07/31/2023, hospice staff informed Assistant Administrator C of multiple bruises of unknown origin observed on both of Resident 2's legs. Resident 2 had diagnoses to include dementia and was unable to explain the cause of the bruises. The provider did not ensure an investigation was completed to determine the source of the injuries.</p> <p>Findings include:</p> <p>The provider is licensed to serve up to 16 non-ambulatory residents from the following client groups; irreversible dementia/Alzheimer's, terminally ill, physically disabled or advanced age.</p> <p>On 08/07/2023 at 12:02 PM, Surveyor interviewed Hospice CNA G. CNA G said in recent weeks s/he reported concerns to Administrator A about Resident 2's care and treatment. CNA G said, "[Administrator A] just basically said whatever to get me out the door. I did not get the sense [s/he] would follow up on it."</p> <p>On 08/07/2023 at 3:06 PM, Surveyor interviewed Administrator A. Administrator A said hospice staff had concerns with Caregiver I's treatment of Resident 2, which included concerns about</p>	N 161		

Wisconsin Department of Health Services

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N 161	<p>Continued From page 11</p> <p>bruises of unknown origin. Administrator A recalled the previous week s/he was told by Caregiver J, "Hospice is taking pictures of the bruises." Administrator A said, "I didn't really do nothing with it... I pretty much, I just said, I told [Caregiver J] you're smoking 20 times an hour maybe you should be in the building to help your coworker. " Surveyor asked if s/he followed up with hospice about the bruising and s/he replied, "I did not. They were here today, but I did not talk to them today."</p> <p>On 08/07/2023 Surveyor reviewed portions of Resident 2's record. Resident 2 was elderly and had diagnoses to include anxiety, hallucinations and dementia. S/he had court appointed guardianship and was protectively placed at the facility. Upon request on 08/09/2023, Administrator A emailed Surveyor Resident 2's observation notes for July and August 2023. The notes did not document bruising. Surveyor reviewed the table of contents for the provider's policy and procedure binder (provided by Administrator A on 08/03/2023). Surveyor noted a policy for responding to injuries of unknown origin was not included in the policy list.</p> <p>On 08/08/2023 at 9:35 AM and 08/14/2023 at 3:08 PM, Surveyor interviewed hospice registered nurse (RN) K. S/he said recently Resident 2 had "bruising out of the blue of the bilateral lower extremities. (They were) all over. Nobody knew how [s/he] got them. Staff said, 'I don't know, we didn't see that'...S/he was complaining of leg pain also." RN K said it was possible the bruises were occurring during staff assisted transfers, but said s/he also had concerns about how Caregiver I treated Resident 2. Hospice RN K stated regardless of the cause it was important for an investigation to be completed to determine the</p>	N 161		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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NAME OF PROVIDER OR SUPPLIER CARE PARTNERS STEVENS POINT 1	STREET ADDRESS, CITY, STATE, ZIP CODE 3349 BUILDING A WHITING AVENUE STEVENS POINT, WI 54481
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N 161	<p>Continued From page 12</p> <p>cause and prevent further injury.</p> <p>On 08/14/2023, RN K sent Surveyor a visit note authored by CNA G, dated 07/31/2023 at 2:19 PM that read, "...HAS BRUISING TO BOTH SHINS, STAFF AND PT (PATIENT) UNSURE OF ORIGIN." RN K included a photo of the bruises taken by CNA G on 07/31/2023. The photo depicted the following:</p> <p>-Left leg - at least 4 bruises brown/green in color on the knee and shin; one was the size of a nickel and the other the size of a quarter.</p> <p>-Right leg - at least 5 areas of bruising brown/green in color on the knee and shin; two areas were as big as 50 cent pieces.</p> <p>On 08/16/2023 at 10:30 AM, Surveyor conducted a follow up interview with Administrator A. S/he described Resident 2 as having significant confusion and "poor" ability to communicate due to his/her diagnoses of dementia. Administrator A verified the provider does not have a policy to address injuries of unknown origin but said the expectation was for staff to chart the bruises in the observation notes or on skin assessment forms completed during showers. During the interview, Administrator A reviewed skin assessment charting and said bruising was not documented during showers on 07/25/2023 or 08/07/2023. Administrator A then checked the hospice communication binder and read Surveyor a note from CNA G on 07/31/2023 that documented the bruise and facility staff's awareness of it. Administrator A confirmed s/he did not personally observe the bruises and an investigation was not conducted to determine the source of the bruises.</p> <p>On 08/16/2023, Administrator A emailed Surveyor</p>	N 161		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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N 161	Continued From page 13 a copy of the note authored by hospice CNA G on 07/31/2023 which read, "Pt (patient) was incontinent of bm (bowel), assisted [Assistant Administrator C] w/changing [him/her] and peri care provided... Bruises on both shins. [Assistant Administrator C] said [s/he] noticed them late last week but was unsure of origin."	N 161		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Caregiver B and Caregiver D received orientation training in all required topics prior to performing any job duties. Caregiver B was hired 10/19/2023. S/he did not receive orientation training in prevention and reporting of resident abuse, neglect and misappropriation of resident property until 4 months after performing job duties. Caregiver D was hired 04/05/2023 and performed	N 230		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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N 230	<p>Continued From page 14</p> <p>job duties on or before 04/10/2023. S/he did not receive orientation training in prevention and reporting of resident abuse, neglect and misappropriation of resident property prior to performing any job duties.</p> <p>This is a repeat deficiency being cited for the 2nd time. See Statement of Deficiency 5MV212, dated 02/25/2021.</p> <p>Findings include:</p> <p>On 08/03/2023, Surveyor requested Caregiver B and Caregiver D's employee records to verify compliance with orientation training requirements.</p> <p>Caregiver B The records for Caregiver B (hired 10/19/2022 - last day worked 04/12/2023), did not contain evidence orientation training was provided in prevention and reporting of resident abuse, neglect and misappropriation of resident property. On 08/08/2023 Surveyor sent an email to Administrator A and requested any additional documentation of orientation training. Administrator A replied, "[S/he] completed ...Prevention and Reporting of Resident Abuse, Neglect, Misappropriation of Resident Property on 02/25/2023." Surveyor noted the training was provided 4 months after Caregiver B was employed.</p> <p>On 08/16/2023 at 10:30 AM, Surveyor interviewed Administrator A. S/he verified Caregiver B was hired on 10/19/2022 and performed job duties from that time until his/her employment was terminated in April 2023. S/he verified Caregiver B did not receive training in abuse/neglect/misappropriation until 4 months after hire.</p>	N 230		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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N 230	<p>Continued From page 15</p> <p>Caregiver D The records for Caregiver D (hired 04/05/2023 - last day worked 04/13/2023), did not contain evidence orientation training was provided in prevention and reporting of resident abuse, neglect and misappropriation of resident property. An orientation checklist identified a "start date" of 04/05/2023 and had a handwritten note, "Three days off training and quit." The employee signature/date line was blank, as was the training category for "Abuse Prevention Training/Cert." [sic]</p> <p>On 08/08/2023 Surveyor sent an email to Administrator A and requested any additional documentation of orientation training. Administrator A replied, "[Caregiver D] was still in the training process when this incident happened (incident of alleged abuse on 04/11/2023) and had resigned in [his/her] third day. [S/he] was to complete the mods 2, 3, 4 on [his/her] training days." The email contained another training checklist; module 3 was abuse prevention. The completion date for the module was blank.</p> <p>On 08/03/2023 and 08/14/2023 Administrator A provided Surveyor with 2 different versions of the April 2023 schedule. The schedules did not include last names, duties, times worked and were not accurate. For example, one schedule (the one Administrator A said was most accurate) did not document Caregiver D worked 3rd shift on 04/11/2023. However, based on a self-report submitted by the provider on 04/17/2023, Caregiver D worked 3rd shift on 04/11/2023 and was alleged to have abused Resident 1. The other version of the schedule noted to be "Updated & Posted 4-18-23," documented Caregiver D began performing job duties from</p>	N 230		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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N 230	<p>Continued From page 16</p> <p>04/09/2023 and continued through 04/14/2023.</p> <p>On 08/16/2023 at 10:30 AM, Surveyor interviewed Administrator A about the schedules and Caregiver D's job duties. Administrator A confirmed the schedules were confusing and inaccurate, but explained it was likely Caregiver D first performed job duties during 3rd shift 04/10/2023 while training with Caregiver B. Then, beginning 04/11/2023 and 04/12/2023 3rd shift, worked more independently providing direct resident care. S/he said Caregiver D resigned after 3rd shift 04/12 into 04/13/2023.</p> <p>Cross reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0348 DHS 83.32(3)(d) Rights of Residents: Free from Mistreatment</p>	N 230		
N 277	<p>83.25 Continuing education</p> <p>The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid.</p> <p>This Rule is not met as evidenced by:</p>	N 277		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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N 277	<p>Continued From page 17</p> <p>Based on record review and interview, the provider did not ensure Assistant Administrator C and Caregiver J received continuing education training in all required topics.</p> <p>The provider did not ensure Assistant Administrator C and Caregiver J received continuing education in client group or resident rights during 2022.</p> <p>Findings include:</p> <p>On 08/03/2023 and 08/08/2023, Surveyor requested Assistant Administrator C and Caregiver J 's employee records to verify compliance with continuing education training requirements.</p> <p>Assistant Administrator C (hire date 10/21/2022) Assistant Administrator C's training records did not include evidence of training in client group or resident rights during 2022. On 08/08/2023, Surveyor sent an email to Administrator A and asked him/her to send any additional evidence of 2022 continuing education. Administrator A replied saying s/he could not locate 2 months of training documentation during 2022 under a previous administrator and s/he did not provide additional documentation to show the training topics were provided.</p> <p>Caregiver J (hire date 08/12/2021) Upon request on 08/08/2023, Administrator A emailed Surveyor all of Caregiver J's continuing education training records for 2022. The records did not include evidence of training in client group or resident rights.</p> <p>On 08/16/2023 at 10:30 AM, Surveyor conducted an exit interview with Administrator A and</p>	N 277		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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N 277	Continued From page 18 reviewed the training deficiencies for Assistant Administrator A and Caregiver J. Administrator A did not provide additional information or evidence that the training was provided. Cross reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect	N 277		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment 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, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was free from abuse. On 04/11/2023, Caregiver B raised his/her voice and swore at Resident 1, denied Resident 1's request to be medically assessed for pain, and jumped on top of Resident 1 to take away his/her cell phone and prevent Resident 1 from calling 911. DHS 83.02(1)(1) "Abuse" has the meaning given in s. 46.90 (1), Stats.(a):...Physical abuse...Emotional abuse (language or behavior that serves no legitimate purpose and is intended	N 348		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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N 348	<p>Continued From page 19</p> <p>to be intimidating, humiliating, threatening, frightening, or otherwise harassing, and that does or reasonably could intimidate, humiliate, threaten, frighten, or otherwise harass the individual...)... Unreasonable confinement or restraint."</p> <p>Findings Include:</p> <p>The department received a complaint that caregivers mistreat residents and refuse to provide needed care.</p> <p>The department received a self-report from the provider on 04/17/2023 which documented abuse against Resident 1 by Caregiver B. The documentation included the following reports/statements:</p> <p>A statement from Resident 1 dated 04/13/2023, authored by Administrator A read, "[Resident 1] reported to me that [Caregiver B] came into [his/her] room around 11 pm on 4/11/2023 and stated that [s/he] could not use the phone to call 911 to go to the Emergency Dept. [Resident 1] was complaining of pain in [his/her] groin area. [Resident 1] stated that [s/he] was going to use [his/her] cell phone to call then and [Caregiver B] (illegible) jumped at [him/her] and grabbed [his/her] phone out of [his/her] hand and stated that [s/he] doesn't need to make a call. This is against Resident Rights. [Resident 1] also stated that [Caregiver B] was raising [his/her] voice and swearing and stating that [s/he] needed to wait for day shift to help [him/her] that it wasn't [his/her] job. This is also against Resident rights." [sic - all] The document was signed by Administrator A and Resident 1</p> <p>An incident report and statement authored by</p>	N 348		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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N 348	<p>Continued From page 20</p> <p>Assistant Administrator C on 04/12/2023, documented that s/he received a call from Caregiver B during the aforementioned incident on 04/11/2023. During the call Caregiver B admitted to Assistant Administrator C "s/he reached over and grabbed [Resident 1]'s cell phone from [his/her] hand and refused to give it back...claimed that [him/her] calling would just make the facility look stupid so [s/he] had to take the phone..." Assistant Administrator C informed Caregiver B this was a rights violation, instructed him/her to return the cell phone and said s/he would arrive onsite soon. Assistant Administrator C wrote, "When writer spoke to [Resident 1] s/he claimed [s/he] was assaulted and that [Caregiver B] physically jumped on [him/her] to grab [his/her] phone from [him/her]."</p> <p>An investigation summary authored by Administrator A indicated Resident 1 was not assessed at the emergency department until the following afternoon. [S/he] was diagnosed with a urinary tract infection and had the catheter tubing replaced.</p> <p>On 08/03/2023, Surveyor reviewed the provider's current Abuse and Misconduct Policy, provided by Administrator A. The policy read in part, "Care Partners...believes that all people deserve dignified, loving care...Our plan shall assure protection of each resident from possible abuse...'Abuse' means any of the following, if done intentionally....An act, omission or course of conduct by another that is not part of a treatment plan...and does any of the following: 1. Results in physical pain or injury, illness...2. Intimidates, humiliates, threatens, frightens, or otherwise harasses a resident. 3. Substantially disregards a resident's rights...or a caregiver's duties and obligations to the resident..."</p>	N 348		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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N 348	<p>Continued From page 21</p> <p>On 08/03/2023, Surveyor reviewed Resident 1's facility file. Resident 1 had diagnoses to include left side weakness due to stroke. His/her individual service plan documented Resident 1 uses a wheelchair for ambulation, relies on staff assistance with all transferring needs and is his/her own legal decision maker.</p> <p>On 08/03/2023, Surveyor interviewed Resident 1. [S/he] was clear in his/her communication and said s/he was not happy living at the facility. Resident 1 confirmed the information detailed in the 04/13/2023 statement. Resident 1 explained the incident started when a different caregiver was rough during cares, pulled on his/her catheter tubing and caused him/her pain. Resident 1 asked Caregiver B to send him/her to the emergency room for evaluation. S/he denied the request. Resident 1 said s/he started to call 911 on his/her personal cell phone and "that's when [Caregiver B] jumped in, [s/he] physically attacked me to get my phone away. [S/he] is a big [person]." Resident 1 further explained all this occurred while s/he was laying in bed and Caregiver B jumped on top of him/her in the bed to reach across his/her body and physically take away the cell phone. Resident 1 commented, "I still don't feel safe here."</p> <p>On 08/03/2023 Surveyor interviewed Administrator A. S/he verified the information in the self-report and said his/her investigation substantiated abuse by Caregiver B, resulting in his/her employment being terminated.</p> <p>On 08/14/2023 Surveyor received and reviewed Stevens Point Police Department Report C23-03550 which read in part:</p>	N 348		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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N 348	<p>Continued From page 22</p> <p>"On 04/12/2023 at approximately at 12:10 PM, I [Officer H] was dispatched to 3349 Whiting Ave., Care Partners, building A...for a report of a disturbance...I went into [Resident 1's] room... [s/he] stated, "last night [Caregiver B] wanted to take away my phone when I was laying in bed and [s/he] jumped on top of me." Resident 1 further explained the phone was taken away while Resident 1 was trying to call 911 due to an issue with his/her catheter after another staff person pulled on his/her leg (where the tubing was attached.) [Resident 1] told Officer H s/he had not yet been medically assessed and said, "It feels like I am pissing razor blades." [Resident 1] again stated the employee jumped on top of [him/her] to try and take [his/her] phone to prevent [him/her] from calling 911... (and) explained the left side of [his/her] body is paralyzed so [s/he] was, 'totally defenseless'. [Resident 1] went on to say there was a 'struggle' for awhile while [s/he] was holding onto [his/her] phone and [Caregiver B] was trying to take it from [him/her]. [Resident 1] then added that [Caregiver B]'s whole body was on top of [him/her]..."</p> <p>On 04/21/2023 Officer H interviewed Caregiver B. S/he stated during the early morning hours of 04/12/2023 Resident 1 reported Caregiver D pulled on his/her leg, disrupted his/her catheter and it caused him/her "to feel like [s/he] was urinating razor blades." Caregiver B said Resident 1 requested s/he document the incident and Caregiver B told [Resident 1] s/he would do it later because s/he was busy cooking food for other residents. Caregiver B estimated this occurred at approximately 2:00 AM. Caregiver B said this upset Resident 1 who said s/he was going to call the police. Caregiver B admitted taking Resident 1's phone from his/her hand to stop Resident 1 from calling.</p>	N 348		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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NAME OF PROVIDER OR SUPPLIER CARE PARTNERS STEVENS POINT 1	STREET ADDRESS, CITY, STATE, ZIP CODE 3349 BUILDING A WHITING AVENUE STEVENS POINT, WI 54481
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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
N 348	Continued From page 23 Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect	N 348		
N 427	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation and interview, the provider did not provide daily activity programming to meet the needs, interests and capabilities of the residents. Findings include: On 08/03/2023 beginning at 9:20 AM, Surveyor conducted a tour of the facility accompanied by Administrator A. Surveyor observed a posted activity calendar for August 2023. The first four days of the month were blank. Beginning Saturday 08/05/2023, activities were listed but times were not included. For example, on	N 427		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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NAME OF PROVIDER OR SUPPLIER CARE PARTNERS STEVENS POINT 1	STREET ADDRESS, CITY, STATE, ZIP CODE 3349 BUILDING A WHITING AVENUE STEVENS POINT, WI 54481
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N 427	<p>Continued From page 24</p> <p>Monday 08/07/2023, the listed activities were:</p> <p>Exercise Soft Music Price is Right Bingo in Afternoon I Love Lucy Show Evening Social</p> <p>On 08/03/2023, Surveyor was in the facility from 8:15 AM to 10:25 AM and 1:05 PM to 3:45 PM. Soft music was playing throughout the day and age-appropriate programming was playing on a TV in the dining room, however Surveyor did not observe any residents engaged in activities. For most of the day, Resident 3 was observed sleeping on the couch in front of the TV in the front living room.</p> <p>On 08/03/2023 at 3:25 PM, Surveyor interviewed Resident 3 and asked how s/he liked living at the facility. Resident 3 said s/he "hates it here."</p> <p>On 08/07/2023, Surveyor was in the facility from 8:13 AM to 8:20 AM, 8:28 AM to 10:30 AM, and 10:55 AM to 4:24 PM. For most of the day, Resident 3 slept on the couch in front of the TV in the front living room. The TV in the dining room was tuned into a program but it was frozen on the screen. Surveyor did not observe residents engaged in exercise, watching the Price is Right or I Love Lucy or playing bingo.</p> <p>On 08/07/2023 at 8:15 AM, Surveyor interviewed Resident 4 and asked how s/he liked living at the facility. S/he replied, "I don't like it," and it's always "the same old faces." Surveyor asked if the provider offers activities and s/he replied, "No, they don't do nothing." Surveyor asked what types of activities s/he would be interested in and s/he</p>	N 427		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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NAME OF PROVIDER OR SUPPLIER CARE PARTNERS STEVENS POINT 1	STREET ADDRESS, CITY, STATE, ZIP CODE 3349 BUILDING A WHITING AVENUE STEVENS POINT, WI 54481
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N 427	<p>Continued From page 25</p> <p>replied, "Anything."</p> <p>On 08/07/2023 at 2:06 PM, Surveyor interviewed Caregiver J who had just completed his/her shift. S/he acknowledged s/he did not offer activities to residents during the shift but was unsure if his/her coworker had. (Surveyor observed this was a small facility and if activities had occurred in the common area they would have been observed.) Surveyor asked what the scheduled activities were for the day and Caregiver J replied, "Game show. I can't remember the rest." Caregiver J recalled the previous day they "listened to polkas" and s/he attempted to show a movie, but Resident 3 didn't like it so s/he turned it off. Caregiver J could not recall the name of the movie.</p> <p>On 08/07/2023 at 3:06 PM, Surveyor interviewed Administrator A and informed him/her that no activities were observed during the 2 onsite visits. Administrator A confirmed Surveyor's observations and volunteered the TV in the dining room was not working today so residents would not have been able to watch the game show activities listed on the calendar. Administrator A explained they have been without an activity coordinator for about 2 weeks but s/he was hoping to hire one soon. Administrator A also stated residents want activities and have been asking for them since the activity coordinator position has been vacant.</p> <p>On 08/07/2023 Administrator A provided Surveyor documentation of a Satisfaction Survey completed by Resident 2's guardian dated 07/18/2023. Resident 2's guardian identified concerns about a lack of activities and wrote, "I've never seen any activities...socialization, person centered care limited...(zero) activities seen by</p>	N 427		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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NAME OF PROVIDER OR SUPPLIER CARE PARTNERS STEVENS POINT 1	STREET ADDRESS, CITY, STATE, ZIP CODE 3349 BUILDING A WHITING AVENUE STEVENS POINT, WI 54481
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N 427	<p>Continued From page 26</p> <p>any resident in months...I'd move my ward if I could..." Administrator A also provided Surveyor an email s/he sent to the corporate office in response to the guardian feedback which read in part, "Activities - we had a [guy/girl] but [s/he] couldn't handle the residents...and resigned. I have [a current 2nd shift staff] in mine [sic] for this but training new staff on second shift to cover [his/her] floor hours."</p> <p>According to the National Library of Medicine, "...A critical aspect of supporting people with dementia is facilitating their participation in meaningful activities...activity provision for people with dementia goes beyond mere pleasure to meeting fundamental psychological needs...spiritual/religious activities address the need for death preparation; intergenerational activities address the need for intergenerational relationships; re-acquaintance with previously conducted leisure activities addresses the need for a sense of control and to achieve life goals; and pursuit of new leisure activities addresses the need to be creative...Conclusion: We argue for the importance of activity provision for people with dementia to help promote wellbeing among an increasing proportion of older people." Source: https://pubmed.ncbi.nlm.nih.gov/26933079/, retrieval date 08/16/2023</p> <p>The provider is licensed to serve up to 16 non-ambulatory residents from the following client groups; irreversible dementia/Alzheimer's, terminally ill, physically disabled or advanced age.</p>	N 427		
N 489	<p>83.44(2)(a) Rooms clean and free from odors.</p> <p>The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free</p>	N 489		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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NAME OF PROVIDER OR SUPPLIER CARE PARTNERS STEVENS POINT 1	STREET ADDRESS, CITY, STATE, ZIP CODE 3349 BUILDING A WHITING AVENUE STEVENS POINT, WI 54481
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N 489	<p>Continued From page 27</p> <p>from odors.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not make reasonable attempts to keep all rooms clean and free from odors.</p> <p>Resident 3's room had a strong smell of urine. The room shared by Residents 4 and 5 was not clean and had an overpowering odor.</p> <p>Findings include:</p> <p>Resident 3's room:</p> <p>On 08/03/2023 at 9:25 AM, Surveyor toured Resident 3's room accompanied by Administrator A. Surveyor detected an overpowering smell of urine. Administrator A confirmed the odor and said, "This [person] likes to pee and poop on the floor." Surveyor did not observe obvious signs of recent incontinence. Surveyor observed Resident 3's bed was not made, the white bed sheet had dried yellow and brown stains/smears and the mattress did not have a mattress pad. Administrator A acknowledged the sheets were in need of being washed and summonsed staff to do so.</p> <p>On 08/07/2023 at 9:55 AM, Surveyor again observed the strong odor of urine in Resident 3's room. Caregiver J agreed the room smelled strongly of urine. Surveyor observed Resident 3's bed had only a flat sheet (no fitted sheet) that was partially untucked, exposing a plastic mattress cover. Caregiver J said s/he had laundered and put away Resident 3's complete sheet set the previous day but did not put them on the bed. S/he retrieved them from the laundry room and</p>	N 489		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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NAME OF PROVIDER OR SUPPLIER CARE PARTNERS STEVENS POINT 1	STREET ADDRESS, CITY, STATE, ZIP CODE 3349 BUILDING A WHITING AVENUE STEVENS POINT, WI 54481
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N 489	<p>Continued From page 28</p> <p>said s/he would change the sheets.</p> <p>On 08/07/2023 Surveyor reviewed Resident 3's face sheet and current individual service plan (ISP) dated 04/23/2023. Resident 3 was elderly, relied on a walker for ambulation and had diagnoses to include diabetes, history of stroke and depressive disorder. the ISP identified the need "Toileting - is incontinent @ times will need minimal reminders to toilet...when upset will have accidents that [s/he] requests help with." The ISP did not identify needs or interventions to manage odors in his/her room. A document in the file identified Resident 3's behaviors which included "urinating or putting feces all over" but the document did not identify interventions to manage the behaviors.</p> <p>Resident 4 and 5's room:</p> <p>On 08/03/2023 at 9:45 AM, Surveyor toured the room shared by Resident 4 and Resident 5. Immediately upon entering the room Surveyor detected a strong, foul odor. Surveyor observed the tiled bathroom floor was dirty and dingy and had areas of dark yellow/brown splatters. The sink was splattered with yellowish-brown spots. The shower floor had brown splatters. The odor in the room caused Surveyor to gag.</p> <p>Resident 4's portion of the bedroom was in need of cleaning and vacuuming with debris, empty wrappers and cigarettes on the floor. Cords, papers, and bags were also scattered on the floor presenting a tripping hazard.</p> <p>Resident 5's portion of the room was in similar condition. The carpet was littered with debris and was in need of vacuuming. The small garbage can next to his/her recliner was completely full</p>	N 489		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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NAME OF PROVIDER OR SUPPLIER CARE PARTNERS STEVENS POINT 1	STREET ADDRESS, CITY, STATE, ZIP CODE 3349 BUILDING A WHITING AVENUE STEVENS POINT, WI 54481
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N 489	<p>Continued From page 29</p> <p>and garbage overflowed on the floor. On the floor near there closet were approximately 15 personal care items which were scattered around and 2 garbage bags storing his/her personal items. Administrator A acknowledged the room was dirty and the odor was overpowering. S/he said the residents are both very messy. As Surveyor left the room Administrator A called out to caregivers, "I need someone to clean (this room) top to bottom!"</p> <p>On 08/07/2023 at 8:17 AM, Surveyor conducted another tour of the room. The sleeping areas were cleaner and more organized than during the 08/03/2023 observations and it appeared the bathroom floor had been cleaned. However, there were 2 dried brown splattered spots on the floor approximately 2-4" in diameter of what appeared to be fecal matter. The sink and the wall near the light fixture both had brown spots and smears of what also appeared to be fecal matter. The toilet had a seat riser. The toilet rim below the riser was covered with large areas of fecal matter. The odor in the bathroom foul and pervasive.</p> <p>While in the room, Surveyor interviewed Resident 5. Surveyor asked if staff assisted with cleaning. S/he said "No, they don't" and said s/he would like more cleaning assistance than s/he receives. On 08/07/2023 at 10:54 AM Surveyor interviewed Resident 4 who was outside in his/her wheelchair. Surveyor observed his/her clothing was dirty and his/her hair was greasy. Resident 5 was neutral about staff assistance with cares and housekeeping but said s/he would not object if they cleaned more often. Resident 5 said it was hard for him/her to do much for him/herself due to the amount of pain s/he was in.</p> <p>On 08/07/2023 Surveyor reviewed Resident 4</p>	N 489		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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NAME OF PROVIDER OR SUPPLIER CARE PARTNERS STEVENS POINT 1	STREET ADDRESS, CITY, STATE, ZIP CODE 3349 BUILDING A WHITING AVENUE STEVENS POINT, WI 54481
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N 489	<p>Continued From page 30</p> <p>and Resident 5's face sheets and ISPs.</p> <p>Resident 5 was elderly with diagnoses to include chronic pain, diabetes, arthritis, epilepsy and Parkinson's disease. Resident 5 was identified as being able to make his/her needs known but was also protectively placed at the facility. The most recent ISP signed and dated 04/24/2023, described Resident 4 as "very nice...always polite." Resident 5 ambulated with a walker and needed stand by staff assistance with bathing to prevent falls. Resident 5's ISP was silent to needs or interventions around housekeeping or cleanliness and indicated s/he was independent with toileting.</p> <p>Resident 4 was elderly with diagnoses to include chronic pain, major depressive disorder, osteoarthritis and mental illness. Resident 4 was admitted 05/13/2023 and his/her ISP was not signed or dated. Resident 4 was identified as being able to make his/her needs known and using a walker for mobility. Resident 4 needed staff cues for bathing/showering. The ISP was silent to needs or interventions around housekeeping or cleanliness.</p> <p>On 08/07/2023 at 09:34 AM Surveyor asked Administrator A about the condition of Resident 4 and 5's bathroom. S/he replied, "them two like to pee and poop wherever. Instead of hitting the toilet they spray all over the place." Surveyor asked if it was possible the residents needed staff assistance with hygiene after toileting, noting both were elderly and used assistive devices for ambulation, potentially impacting their ability to care for themselves or their room. Administrator A acknowledged they both could probably use more staff assistance and said staff have not been meeting expectations for ensuring resident rooms</p>	N 489		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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NAME OF PROVIDER OR SUPPLIER CARE PARTNERS STEVENS POINT 1	STREET ADDRESS, CITY, STATE, ZIP CODE 3349 BUILDING A WHITING AVENUE STEVENS POINT, WI 54481
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N 489	<p>Continued From page 31</p> <p>are clean and free from odors. Administrator A said their room should be cleaned at least twice daily but s/he suspected "no one had been in there since yesterday, or maybe not at all yesterday." Administrator A said after Surveyor's visit on 08/03/2023 s/he posted signs in the medications rooms and with cleaning instructions to staff. Surveyor observed one of the postings on 08/07/2023 at 5:21 PM which read in part, "Memo from Director August 4, 2023...State is here!!...I want the following completed this weekend...All bedrooms and bathrooms of residents cleaned, swept, mopped, toilets clean from top to bottom, vacuumed and organized, all garbage taken out. This should be done daily. They were all very dirty when the state did [his/her] walk through yesterday. Not acceptable...Get this house cleaned by Monday morning. Check residents' beds daily for being soiled, when they are made on day shift you should be looking at this."</p> <p>Cross Reference: N0491 DHS 83.44(2)(c) Interior Floors, Walls and Ceilings</p>	N 489		
N 491	<p>83.44(2)(c) Interior floors, walls and ceilings.</p> <p>Every interior floor, wall and ceiling shall be clean and in good repair.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all interior floors and walls were clean and in good repair. Carpeting in the common areas of the facility was badly worn, stained and had areas of seam separation that presented a tripping hazard.</p>	N 491		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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NAME OF PROVIDER OR SUPPLIER CARE PARTNERS STEVENS POINT 1	STREET ADDRESS, CITY, STATE, ZIP CODE 3349 BUILDING A WHITING AVENUE STEVENS POINT, WI 54481
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N 491	<p>Continued From page 32</p> <p>This is a repeat deficiency being cited for the 3rd time. See Statement of Deficiency QZ1512, dated 07/12/2018 and Statement of Deficiency QZ1513, dated 006/23/2021.</p> <p>Findings include:</p> <p>The provider is licensed to serve up to 16 non-ambulatory residents from the following client groups; irreversible dementia/Alzheimer's, terminally ill, physically disabled or advanced age.</p> <p>Surveyor entered the facility on 08/03/2023 at 8:15 AM and observed the carpeting in the front common area/sitting room was badly worn and stained. Surveyor also detected an odor.</p> <p>Surveyor entered a sitting room to the left/north and observed the room was cluttered and trim along the interior wall at the front of the building was missing.</p> <p>At 8:20 AM, Surveyor conducted the entrance conference with Administrator A. Administrator A volunteered Surveyor would observe concerns with the carpeting throughout the facility which s/he described as "dingy and dark." S/he said the siding on the front of the building hadn't been replaced since winter when a staff member accidentally ran into the building with their vehicle. (Surveyor observed the missing siding upon entrance.) Administrator A said, "They had to replace the walls...They didn't put my trim back on." Administrator A acknowledged there is an odor in the building and attributed it in part to the condition of the carpet. S/he stated the ombudsman was there recently and stated the carpet was so bad it could be an infection control concern. Administrator A said the maintenance staff told him/her the carpet is so worn and thin</p>	N 491		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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NAME OF PROVIDER OR SUPPLIER CARE PARTNERS STEVENS POINT 1	STREET ADDRESS, CITY, STATE, ZIP CODE 3349 BUILDING A WHITING AVENUE STEVENS POINT, WI 54481
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N 491	<p>Continued From page 33</p> <p>it's difficult to shampoo it anymore.</p> <p>Surveyor asked Administrator A to provide evidence of his/her efforts to address the concerns with the carpet. Administrator A provided Surveyor an email s/he sent on 07/27/2023 at 1:48 PM to the corporate office (including Licensee L.) S/he said the email stemmed from a complaint received from Resident 2's guardian. The email read in part, "Carpet is beyond repair, stained, torn, patched, smells, needs replacing...it seems dingy, dark and very run down appearance. Siding...in front of building not completed since winter, trim isn't back up in the sitting area...I have had ombudsman here also quite bit walking through like twice a month, this last week [s/he] asked if or when things getting repaired. [S/he] stated we could be cited on the flooring on had bad it is...What can we do to improve this matter. Please help me in Stevens Point..." [sic all]</p> <p>On 08/03/2023 at 9:20 AM Surveyor conducted a tour of the facility accompanied by Administrator A and observed the following:</p> <p>North hall of resident rooms: Seam separation with frayed carpet material in at least 4 places. The carpet was brown in color but the center span the length of the hallway was stained a noticeably darker color.</p> <p>Back hall/exit door: Approximately 16" of the interior door frame was damaged. The white frame had gouges, black streaks and exposed raw wood. The interior of the frame had missing and peeling pieces of weather stripping which exposed gaps of approximately 1/4 " to the outside even when</p>	N 491		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0011953	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/16/2023
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NAME OF PROVIDER OR SUPPLIER CARE PARTNERS STEVENS POINT 1	STREET ADDRESS, CITY, STATE, ZIP CODE 3349 BUILDING A WHITING AVENUE STEVENS POINT, WI 54481
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N 491	<p>Continued From page 34</p> <p>the door was shut. The interior of the door was white but had long black streaks.</p> <p>South hall of resident rooms: The carpet was brown in color but the center span the entire length of the hallway was stained a noticeably darker color. Previous areas of seam separation had been replaced with 5 sections of black carpeting. There was new seam separation and frayed carpet material along the replacement carpeting. One area of seam separation was approximately 10" long by 3" wide and exposed white threads under the brown carpet. The gap in the carpeting presented a tripping hazard. The carpet in the doorway of Resident 4 and 5's shared room was stained a very dark color and had 2 areas of frayed carpeting approximately 4" long. Inside the room, there were at least 20 areas of snagged and frayed carpet.</p> <p>Other areas: The carpet just outside the kitchen entrance was black and stained. The plastic transition strips from the hallway carpet to the linoleum flooring in the dining was missing at least 3 pieces approximately 1-2" in size and presented a tripping hazard for residents.</p> <p>During 2 days onsite, 08/03 and 08/07/2023, Surveyor observed at least 3 residents ambulated with the use of either a walker or a wheelchair.</p> <p>Cross Reference: N0489 DHS 83.44(2)(a) Rooms Clean and Free From Odors</p>	N 491		