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	0018014	A. BUILDING: _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTES PLACE I	1515 A HIGHWAY 175 RICHFIELD, WI 53076

(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
M 000	INITIAL COMMENTS On 01/31/2024, with information gathered through 04/18/2024, Surveyor conducted an abbreviated licensure survey and 3 complaint investigations at Bettes Place 1. Twenty-nine deficiencies were identified. Three of 3 complaints were substantiated. One of the 29 deficiencies was a repeat violations (see Statement of Deficiency (SOD) IZPX11). Census: 3	M 000		
M 114	88.03(3)(b) CRIMINAL RECORDS CHECK Criminal records check. Prior to an initial license the licensing agency shall ask the Wisconsin department of justice to conduct a criminal records check on the license applicant and on any other adult household member. The licensee shall arrange for a criminal records check of all service providers. At least every second year following issuance of an initial license the licensing agency shall request a criminal records check on the licensee and all other adult household members and the licensee shall arrange for a criminal records check on any service provider. In addition, during the period of the licensure, the licensee shall arrange for a criminal records check on any new service provider. If any of these persons has a conviction record or a pending criminal charge which substantially relates to the care of a dependent population, the funds or	M 114		

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

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M 114	Continued From page 1 property of adults or minors or activities of the adult family home, the licensing agency may deny, revoke, refuse to renew or suspend a license, initiate other enforcement action provided in this chapter or in ch. 50, Stats., or place conditions on the license. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 4 personnel files reviewed included a complete background check as required. Caregiver F and Caregiver G did not complete a new Background Information Disclosure (BID) form upon hire when the provider utilized a prior background check completed within the prior 4 years. Licensee A did not conduct a background check for Co-Owner B when s/he began working in the capacity of a service provider. Findings include: On 02/01/2024, Surveyor reviewed Caregiver F's and Caregiver G's record. Caregiver F was hired from 01/10/2023 to 11/24/2023 and rehired on 01/16/2024. His/her file contained a completed background within the previous 4 years, including the following background information:	M 114		

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M 114	Continued From page 2 BID report was not included in record. DOJ report was dated 07/08/2023. IBIS letter was dated 07/08/2023. Caregiver G was hired on 12/12/2020. His/her file did not contain a BID form. On 02/05/2024 at 9:46 AM, Surveyor emailed Administrator A and Administration C of the concern. As of 02/12/2024 at 5:00 PM, Surveyor did not receive a response. On 02/16/2024 at 9:53 AM, Surveyor emailed Licensee A and Administration C and requested Co-Owner B's complete background check, due to his/her involvement with resident cares. On 02/19/2024 at 8:52 AM, Co-Owner B emailed Surveyor and stated, "I apologize that this has not been done before as I had thought that an owner was not under this same requirement as a caregiver." On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C and Assistant Executive Director F. Surveyor did not receive a response as to why the BID form had not been utilized.	M 114		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring	M 134		

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M 134	Continued From page 3 hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the Department within 24 hours a significant change when 1 of 1 resident (Resident 3) fell and broke his/her ankle. Findings include: On 04/09/2024, Surveyor reviewed Resident 3's record. Resident 3's "Incident Report," dated 02/22/2023, written by previous Caregiver KK, documented: "Resident was in room getting clothes ready for the day and staff heard a loud noise. Staff immediately went to residents' room and resident was on floor holding [his/her] right foot." Resident stated, "I was trying to turn fan on and I tripped and slipped on bedsheet." "Taking resident to urgent care to get foot looked at." "Going to [hospital]." On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed Caregiver KK. Surveyor asked if Resident 3 received additional treatment after being transferred to urgent care and then to the hospital. Caregiver KK stated Resident 3 had fractured his/her ankle and was placed in a walking boot.	M 134		

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M 134	Continued From page 4 On 04/09/2024, Surveyor reviewed the providers self-reporting file held by the Department. Surveyor found no written report(s) had been submitted to the Department for Resident 3's change in status, resulting in a walking boot. Surveyor noted that the provider had not submitted a written report since licensure, 05/12/2020. On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C and Assistant Executive Director F. Licensee A stated s/he was not aware of the self-report forms until recently.	M 134		
M 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on record review and interview, Licensee A did not ensure that the home and its operation complied with all laws governing the home and its operation. Staff reported not receiving adequate training to complete resident cares. Licensee A and Co-Owner B dismissed Manager F during the survey process and asked that s/he sign a non-disclosure form. Thirty deficiencies were cited. Findings include:	M 216		

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M 216	Continued From page 5 Example 1: Training On 10/04/2023, the Department received a concern that staff were not accurately trained. On 01/31/2024, 02/13/2024 and 02/14/2024, Surveyor observed Resident 1 in the home, who appeared to be bedbound. Staff were expressing concerns due to Resident 1 not wanting to eat or take his/her medications. On 01/31/2024, at approximately 12:05 PM, Surveyor interviewed Hospice Registered Nurse (RN) K. RN K stated that they were working with Resident 1's refusals of food and medications. On 01/31/2024, Surveyor reviewed Resident 1's record. Resident 1 admitted to the home, 11/14/2023, with diagnoses including Parkinson's disease with dyskinesia, dystonia, muscle weakness, muscle spasm, and depression. Resident 1 was on hospice. On 02/13/2024, at approximately 12:00 PM, Surveyor interviewed Licensee A and Co-Owner B. Co-Owner B explained that not all staff members are comfortable with providing comfort cares for hospice residents. On 02/19/2024, at approximately 1:00 PM, Surveyor interviewed Caregiver H. Caregiver H stated, "There is no official training. Staff usually start at [home] with the hospice patients. Not all of us are comfortable with that. Providing comfort care is hard." On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I.	M 216		

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Caregiver I stated, "[Manager F] would provide training with a PowerPoint but [s/he] did not train one-on-one with new staff. There is no training; staff are just put on the floor and expected to figure it out."

On 02/25/2024, at approximately 9:45 AM, Surveyor interviewed previous Caregiver J. Caregiver J stated that upon hire, care plans are not shared with staff. Caregiver J stated, "You are on a need-to-know basis. I had no experience with a hospice patient, and you are just placed in the home with no additional guidance. We were not set up to take on a hospice patient (Resident 2) at that level; we were told [s/he] had probably like ten days." Caregiver J explained, "[Manager F] teaches the CBRF (community-based residential facility) courses. I completed the Standard Precautions on 10/24/2023 and/or 10/26/2023 training with [Manager F]. I was charged $75. [Manager F] took the test for me. I do not want to get myself in trouble, but I want to be honest."

On 02/25/2024, at approximately 10:35 AM, Surveyor interviewed Resident 5's Power of Attorney (POA) Y. POA Y stated Resident 5 had resided at the home for 3 years and staff are still unfamiliar with Resident 5. POA Y stated, "[Resident 5] needs to be assisted to the bathroom. I do not know if this is occurring. I do know that [Resident 5] will have feces on [his/her] hands, under [his/her] fingernails, and staff do not realize this. So, I will arrive to spend time with [Resident 5] and I am cleaning [him/her] up."

On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Caregiver M stated, "They just assume you know what to do because you have prior experience,

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but every resident is different. You should have a basic understanding of the resident before you approach them. Same with medications; they never showed me med pass, they just said you have previous training, do it."

On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Manager N stated, "The day [Resident 1] moved in (11/14/2023), [Manager F] did not have a care plan ready to share with the staff. I discussed this concern with [Manager F]. I wanted to know why [s/he] didn't have information to give to the staff. Of course, [s/he] had no response." Manager N also explained there were concerns with Manager F not properly training staff. Manager F was an approved trainer for the CBRF department approved courses. The provider requested staff complete these courses. Manager N stated, "[Manager F] was not completing the courses as outlined and was taking the tests for the staff. I discussed this with Co-Owner B and [s/he] said [s/he] would take care of it, but [s/he] was allowed to continue [his/her] process."

On 03/02/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver L. Caregiver L stated, "I do not recall any specific training regarding residents, especially hospice. I never shadowed an employee; you are just placed on the schedule. I was never given a care plan until [Manager E] was hired - s[h/e] said I will not put you back onto the schedule until you read all of this - [s/he] knew none of the staff had read them and it was a big deal to [him/her] to have everybody become familiar with the ISPs. I have never seen [Manager F] provide cares for a resident, let alone show another staff member how to care for a resident."

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M 216	Continued From page 8 On 03/02/2024, at approximately 10:35 AM, Surveyor interviewed Caregiver O. Caregiver O stated, "I felt like [Co-Owner B] and [Licensee A] would ignore [Resident 6]. [Resident 6] was non-verbal, so [s/he] would yell and point at things and they would respond like 'mmhmmm' and brush [him/her] off. Then us staff are trying to figure out what [Resident 6] needs and how to care for [him/her]." On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Caregiver W stated, "We do not see the ISPs. We are told, you have experience, why do you need to see the ISPs?" Caregiver W explained that s/he did not know Resident 3 abused opioids and that was why s/he was prescribed Narcan. Caregiver W stated, "We aren't trained for that!" Caregiver W stated, "[Resident 6] had significant behaviors. [S/he] would throw [him/herself] on the ground. Medications did not help. Nobody knew what to do and management didn't help. [Resident 6] was non-verbal, would just yell and scream and point, nobody knew how to communicate with [him/her]." On 03/06/2024, at approximately 5:10 PM, Surveyor interviewed Resident 5's Power of Attorney (POA) Y. POA Y stated, "I receive calls/texts at all hours when [Resident 5] is upset or having some kind of behaviors, asking me to help calm [him/her] down. I think staff are not trained; they go through staff so quickly lately." On 03/08/2024, at approximately 10:45 AM, Surveyor interviewed previous Caregiver V. Caregiver V stated s/he did not receive any training, because management told him/her that s/he had previous experience and should not	M 216		

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need additional training. Caregiver V stated, "If you questioned a resident's care, [Manager F] might show you that person's ISP. It was a hit or miss."

On 03/10/2024, at approximately 12:10 PM, Surveyor interviewed Resident 3's Family Member (FM) AA. FM AA stated Resident 3 had a traumatic brain injury and staff are contacting him/her when s/he is upset, as they do not know how to calm him/her down. FM AA stated, "I would think staff would know the resident and know how to redirect [him/her]. I think more training should be provided."

On 03/10/2024, at approximately 2:20 PM, Surveyor interviewed Resident 4's POA II. POA II stated, "Unfortunately, while visiting, I would see staff sitting around, playing on their phones."

On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver S. Caregiver S stated, "I didn't receive training. You are just thrown on to the schedule and expected to know what to do. I had never worked with an electronic medication administration record system. Every facility I worked at was still using paper. I had to figure it out on my own." Caregiver S stated, "Staff were not comfortable with hospice patients and did not always understand how to provide appropriate cares. Like [Resident 4], I would come in to start my shift and [s/he] would always be soaked head-to-toe. I always wondered why staff didn't change him/her, but maybe they didn't feel comfortable with it." Caregiver S stated, "[Resident 6's] [mom/dad] made the caregivers a care plan book, so staff would know how to provide cares for [him/her]. Management didn't give us any information. [Resident 6] did not get good care at the home.

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[S/he] was left to sit in a chair and staff yelling at [him/her]. Staff just didn't know how to interact with [him/her]." Caregiver S stated, "A lot of the staff were not trained. Then [Manager F (currently Assistant Executive Director [AED] F)] would be trying to do medication training over the speakers, not face-to-face."

On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver JJ. Caregiver JJ stated, "[Resident 4] would always be soaked and at times double briefed. Staff weren't trained on how to provide proper cares to residents. What was acceptable and what wasn't." Caregiver JJ and previous Caregiver KK stated, "[Resident 6] spoke with sign language and [s/he] was a full assist in everything. A lot of the staff did not understand how to communicate with [him/her]." Caregiver JJ and Caregiver KK stated, "Also, when there was an actual activity person, they often did not know how to work with the residents, so, if a resident was 'difficult,' they would just put them back into their room."

On 04/10/2024, at approximately 5:00 PM, Surveyor interviewed Caregiver JJ and Caregiver KK. Caregiver JJ and Caregiver KK stated, "There have been employees that barely understood English, so when they were receiving training, [Manager F] and [Licensee A] would help provide the answers for these staff members. Other times, we would be called in for last minute training for skype training being put on by [Trainer OO]. Staff would be texting [Licensee A] to get the answers. How do you know if your staff is properly trained?"

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C

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and AED F. Licensee A, Co-Owner B, Administration C and AED F communicated amongst themselves and discussed what changes needed to occur regarding training for staff.

Example 2: Non-disclosure Forms

On 02/19/2024, at approximately 7:50 AM, Surveyor received a call from Manager E. Manager E stated s/he had just been informed that [his/her] employment was being terminated. Manager E stated, "[Licensee A] and [Co-Owner B] presented me with this form and asked me to sign it. I am looking at it and here it is a non-disclosure form asking that I not discuss the home or them outside of the facility. They promoted [Manager F] to [EAD F]. I don't think they want me talking to you, but I going to continue to. You need to know what is going on in those homes."

On 03/06/2024, at approximately 12:00 PM, Surveyor interviewed Co-Owner B. Surveyor asked for clarification of the described concern. Co-Owner B stated, "I am sure [Manager E] would agree that [s/he] was not a good fit for our homes and we need to ensure that gossip/lies do not get spread. I have to think about the reputation of the homes and myself."

Example 3: Cites

On 01/31/2024, with information gathered through 04/12/2024, Surveyor conducted an abbreviated licensure and 3 complaint investigations. As a result of the survey, 30 deficiencies, including this one, were identified:

Licensee/Owner:

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M 216	Continued From page 12 -Licensee A allowed documentation to be amended/deleted to ensure the appearance of resident care/medication administration was being provided. -Licensee A allowed documentation to be amended/deleted to ensure the appearance of resident care/medication administration was being provided. -Licensee A did not report to the Department when resident property was misappropriated, when residents alleged misconduct by a staff member, and/or when residents sustained an injury requiring medical treatment. -Licensee A did not investigate when residents/staff alleged misconduct by a staff member and a resident sustained injuries-of-unknown origin. -Licensee A did not ensure staff members were properly insured when transporting residents with their personal vehicles. -Licensee A did not ensure residents were provided cares by staff who were not impaired by illicit drugs -Licensee A did not ensure residents personal information was kept confidential. Resident Care: - Two of 3 resident records did not include comprehensive individual service plans. - One of 3 residents individual service plans did not identify required supervision for a resident who was an elopement risk. - Two of 2 hospice residents were considered a point-of-rescue during a fire drill and the provider did not have an evacuation plan. - Three of 3 residents did not receive organized activities. - Two of 3 residents did not receive transportation to medical appointments and/or assistance during medical appointments.	M 216		

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M 216	Continued From page 13 -One of 3 residents did not receive meals and snacks based on diet restrictions. -Two of 2 residents did not receive health monitoring. -One of 1 resident written orders were not received/followed. -Four of 4 residents did not receive medication as prescribed. -Two of 2 hospice residents were not provided dignity as rooms were shown to potential residents. -One of 1 resident was not assessed for bed rail after attempting suicide. -One of 1 resident was not ensured the ability to request assistance due to placement of call light. -One of 1 resident did not receive prompt and adequate treatment when s/he attempted suicide. Environment: -Licensee A did not ensure food was prepared and stored in a sanitary way. -Licensee A did not ensure water temperatures did not exceed 115 degrees Fahrenheit. -Licensee A did not ensure toxic chemical compounds were secured. Employees: -Three of 4 employees did not have complete background checks completed. -Two of 2 employees did not have complete training. -One of 2 employees did not have a TB test and communicable disease screen within 90 days prior to providing services. On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C and Assistant Executive Director F. Licensee A stated concerns that the survey process resulted	M 216		

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M 216	Continued From page 14 in several findings. Cross Reference: M0114 DHS 88.03(3)(b) Criminal Records Check M0134 DHS 88.03(5)(e)1. Significant Change to the Resident M0216 DHS 88.04(2)(a) Responsibilities M0230 DHS 88.04(2)(f) Condition Which Represents Risk or Harm M0232 DHS 88.04(2)(g)1. Health Screening For Staff M0240 DHS 88.04(4)(a) Insurance - Vehicle M0246 DHS88.04(5)(b) Training - 8 Hours Annually M0342 DHS 88.05(4)(d)1. Fire Safety Evacuation Plan M0406 DHS 88.06(3)(b) Persons Involved With ISP & Assessment M0408 DHS 88.06(3)(c) Assessment Identify Needs & Abilities M0410 DHS 88.06(3)(d) Individual Service Plan M0414 DHS 88.06(3)(d)2. Level of Supervision M0430 DHS 88.07(1)(c) Activities and Services M0444 DHS 88.07(2)(b)3. Transportation to Medical M0448 DHS 88.07(2)(b)5. Monitoring Health M0462 DHS 88.07(3)(c) Medication Assistance M0464 DHS 88.07(3)(d) Medication - Written Order M0466 DHS 88.07(3)(e)1. Medication - Record Keeping M0470 DHS 88.07(4)(a) Nutrition M0474 DHS 88.07(4)(c) Food Prepared and Stored Sanitary Way M0478 DHS 88.07(4)(e) Special Diets M0482 DHS 88.09(1)(a) Resident Records M0548 DHS 88.10(3)(a) Fair Treatment M0552 DHS 88.10(3)(c) Confidentiality M0570 DHS 88.10(3)(l) Safe Physical Environment	M 216		

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M 216	Continued From page 15 M0572 DHS 88.10(3)(m) Freedom From Abuse M0574 DHS 88.10(3)(n)1. Freedom From Seclusion And Restraints M0580 DHS 88.10(3)(p) Prompt and Adequate Treatment Z0055 2 - DHS - 13.05 (3) (a) Entity Allegation Reporting Requirements L0104 441.301(c)(4)(vi)(B)(1) Residential Setting: Living Unit Locks	M 216		
M 230	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm. This Rule is not met as evidenced by: Based on observation, interview and record review, the licensee permitted a condition of risk which placed the health, safety, and welfare of residents at substantial risk of harm. The licensee did not implement a process to ensure staff are not under the influence of illicit drugs while caring for residents. Findings include: This provider is licensed to care for up to 4 residents in the client groups of: irreversible dementia/Alzheimer's disease, physically disabled, emotionally disturbed/mental illness, developmentally disabled and advanced aged. On 10/04/2023, the Department received a	M 230		

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concern that alleged staff members were doing drugs in the home that resulted in law enforcement contact.

On 01/31/2024, at approximately 11:30 AM, Surveyor interviewed Co-Owner B and Manager R. Surveyor stated s/he was investigating an allegation that staff were doing illegal drugs in the home in 09/2023. Co-Owner B acted shocked that such an incident would occur in his/her home. After a bit, Co-Owner B stated, "Oh that must be regarding previous Caregiver Z." Co-Owner B stated that s/he suspected for months that Caregiver Z was working under the influence but could not prove it. Co-Owner B explained, "[S/he] seemed unfocused/distant/stare off into space/late for work." Co-Owner B stated when s/he was informed that staff were suspicious of another staff member engaging in illicit drugs at work, s/he contacted the police. When the police arrived, s/he denied the drugs were [his/hers] and refused to take a drug test. [S/he] was sent home that day. Caregiver Z was given a drug test on another day which came back negative. Co-Owner B stated, "Police were unable to confirm drug that was found in the home." Surveyor asked if the provider had conducted an internal investigation. Co-Owner B stated, "Our internal investigation was contacting law enforcement. We do not tolerate that type of activity in our home."

On 01/31/2024, at approximately 12:50 PM, Surveyor interviewed Caregiver F (Assistant Executive Director F). Caregiver F explained s/he was the manager during the time staff were suspected of doing drugs in the home. Caregiver AA and Caregiver BB had contacted him/her that drugs were being consumed in the vacant

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resident private bathroom, located in adjoining home. Caregiver F stated s/he called Co-Owner B and Co-Owner B called the police. The police tested the powder residue that was on the bathroom countertop and determined it was cocaine. Caregiver F stated, "[Caregiver Z] denied the drugs were [his/hers] but I sent [him/her] home. [S/he] was to do a drug test but [s/he] wouldn't come in." Surveyor asked why only Caregiver Z was asked to give a drug test. Caregiver F stated, "Due to [his/her] actions, [s/he] had slurred speech, couldn't stay focused." Surveyor asked if Caregiver Z, Caregiver AA, and Caregiver B worked in the home again. Caregiver/Manager F stated Caregiver Z was removed from the schedule. Surveyor asked if staff rotated between the 3 homes, since the homes are under one roof. Caregiver F stated staff did rotate between the 3 homes. Surveyor requested the staff schedule for September 2023 of individuals who worked the assigned schedule.

On 02/01/2024 at 6:57 AM, Surveyor requested from Licensee A any internal documentation regarding the alleged allegation of drugs in the home due to staff from 09/2023. Licensee A responded with a statement that read:
"On Monday 9/25/2023, [Caregiver AA] reported to [Manager F] that [s/he] thinks [Caregiver Z] was high on cocaine. [S/he] thought it was suspicious because [Caregiver Z] had the window open in the private suite's bathroom (Resident 1). [Caregiver AA] said [s/he] saw some white powder on the bathroom counter. [S/he] immediately got dizzy when [s/he] took a whiff of the countertop residue. [Manager F] informed [Co-Owner B]. [Co-Owner B] called [Sheriff's Office]. Officer showed up. [S/He] spoke with [Caregiver Z] for a while and could not prove that [Caregiver Z] was the user. [Caregiver Z] did not

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appear to be high on drugs per the officer. The officer went to test the counter in the bathroom for elicit substances and concluded that it was positive for cocaine. Both [Caregiver Z] and [Caregiver AA] refused to be drug tested. [Caregiver Z] started work at 3pm. [S/he] was sent home at 5:45pm. On Tuesday 9/26/2023, [Caregiver Z] consented to be drug tested. The result was negative. It was not able to be 100% determined if [Caregiver Z] used cocaine during work time."

On 02/02/2024, Surveyor requested the sheriff reports, from 09/01/2023 to 10/31/2023, from the county sheriff department that pertained to the address of the home.

On 02/02/2024 at 8:39 AM, Surveyor emailed Licensee A and requested Caregiver Z's drug test results and the provider's drug policy. Licensee A submitted the drug policy and a picture of a drug testing pee cup that contained what appeared to be urine. Surveyor responded to Licensee A and requested additional evidence of test results. As of 02/10/2024 at 8:00 AM, Surveyor did not receive additional documentation.

The providers "Drug and Alcohol Testing" policy documented:
"In support of our commitment to a safe work environment free from the use or effects of illegal drugs and/or alcohol. The Company, in its sole discretion, reserves the right to test any employee for illegal drugs at any time, or alcohol should there be reason to suspect that an employee may be using illegal drugs or may be under the influence of alcohol due to, but not limited to, an employee's conduct, appearance, behavior, speech, or body odors indicative of drug or alcohol use. The Company reserves the right to

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terminate an employee if drug or alcohol test results are positive."

On 02/06/2024, Surveyor reviewed the sheriff's reports which documented:

"09/25/2023 17:13:29 (5:13 PM) - Caller states that they believe one of the employees is using Cocaine at work - [s/he] seems impaired per On-Duty Manager (Manager F), found white powdery residue on counter. Suspect is [Caregiver Z] ... I met with [Manager F] regarding a white substance [s/he] found located on the counter of one of the bathroom sinks. [Manager F] and employee [Caregiver AA] believed that their co-worker [Caregiver Z] was in the bathroom earlier using an illegal drug as [s/he] emerged from the bathroom acting weird. I met with and spoke to [Caregiver Z] who admitted to using THC, Cocaine and Heroin in the past but stated [s/he] hasn't used any at work. With the bathroom being used by all staff and residence and with a minute amount of residue on the sink there was no positive identifying way to establish possession. [Caregiver Z] did not have any property on scene and was asked to leave the workplace by [Manager F] upon my testing and identification of the white residue which tested positive for cocaine."
(Surveyor noted Co-Owner B stated the police were unable to determine the drug.)
(Surveyor noted to utilize vacant private bathroom, one would have to walk through the room. Other residents were not allowed to use the private bathroom.)
"10/21/2023 09:04:02 (9:04 AM) - [Caller] stated that staff has been using drugs in the parking lot."

On 02/13/2024, at approximately 3:50 PM, Surveyor interviewed Lead Caregiver P. Lead

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Caregiver P stated previous Caregiver V and Co-Owner B initiated the drug test for Caregiver Z.

On 02/14/2024, at approximately 11:20 AM, Caregiver/Manager F stated that staff had contacted him/her regarding the concern, and s/he stated that 911 needed to be called.

On 02/14/2024, at approximately 11:55 AM, Surveyor interviewed Co-Owner B. Co-Owner B stated, "If a staff member or a resident brings a concern to me, I immediately tell them to stop and I bring in another person, usually the manager, to listen to the concern. We often have 3-way calls. I expect the managers to write the required incident reports and to conduct the internal investigations." Co-Owner B stated s/he was not aware of any staff being investigated for alleged marijuana use while on schedule.

On 02/14/2024, at approximately 1:30 PM, Surveyor interviewed Licensee A. Surveyor asked if Caregiver Z was allowed to return to work. Licensee A stated, "Yes, s/he came in the next day and took a drug test. The test came back negative, so, I kept [him/her] on the schedule. Then management told me that I should probably remove [her/him] from the schedule." Licensee A did not continue on with his/her explanation.

On 02/16/2024, Surveyor reviewed the staff schedule which documented:
Caregiver Z remained on the schedule:
09/26/2023 7AM - 3PM
09/28/2023 7AM - 3PM
09/30/2023 7AM - 3PM and 11PM to 7AM
Caregiver AA remained on the schedule:
09/26/2023 3PM - 11PM

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M 230	Continued From page 21 09/27/2023 3PM - 11PM 09/28/2023 3PM - 11PM 09/29/2023 3PM - 11PM Caregiver BB remained on the schedule: 09/26/2023 3PM - 11PM 09/27/2023 3PM - 11PM 09/28/2023 3PM - 11PM 09/29/2023 7AM - 3PM 09/30/2023 3PM - 11PM On 02/19/2024, at approximately 7:50 AM, Surveyor interviewed Manager E. Manager E stated s/he was informed by Licensee A and Co-Owner B that if staff are smoking illicit drugs in their cars and not in the home, then there was no concern. Manager E stated s/he could not understand or accept that because those individuals would then come into the home, under the influence, and attempt to care for their residents. Manager E stated s/he had asked Caregiver F, who was the manager during the 09/25/2023 incident, if they had completed an internal investigation and s/he was informed, no. On 02/21/2024, at approximately 4:30 PM, Surveyor interviewed Family Member CC. Family Member CC stated, "I had a couple of visits to [provider] where I smelled marijuana walking into the building in late afternoon. When I asked staff about the smell, they told me there were residents who smoked it. I remember telling them I had never heard of such a thing, and they responded that it was for medicinal purposes." On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Caregiver I stated s/he would express his/her concerns to Manager F that staff were coming in to work under the influence. Caregiver I stated, "You could just smell the marijuana scent." Caregiver I stated Manager F told him/her, "If we	M 230		

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say anything, then we are not going to have any staff."

On 03/06/2024, at approximately 2:15 PM, Surveyor and county sheriff Detective Y observed staff members for the second shift arriving at the home. Detective Y and Surveyor observed a strong marijuana like aroma emanating from two of the staff members. Staff members interacted with Licensee A and Surveyor observed no comments directed at staff members regarding the aroma and possibility of working under the influence of an illegal drug.

On 03/08/2024, at approximately 10:45 AM, Surveyor interviewed previous Caregiver V. Caregiver V stated Caregiver Z was the only staff member that completed a drug test. Caregiver V stated, "I think they had it out for [Caregiver Z]. They didn't test anybody else. Every time [Caregiver Z] came into the building, they would drug test [him/her]. They never drug tested anybody else. I think that is harassment!"

On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed Caregiver Z. Caregiver Z stated, "I was drug tested by the police, came back negative. Drug tested again by [previous Caregiver G], came back negative. Drug tested again by [Caregiver V], came back negative. It was harassment. The thing is, I was working in the home by myself and then two people show up, new employees (Caregiver AA and Caregiver BB). They are scheduled in the other homes, but they have to come into this home to use the bathroom? Why don't they use the bathroom in their home? Why was I the only one tested and I was the only one suspended?" Surveyor asked if s/he was aware of staff working in the home under the influence of an illegal drug. Caregiver

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Z stated, "They (Co-Owner B and Licensee A) never talk about the individuals who smell like marijuana; they are picking these staff members up to work; they know they are high, but they never say anything."

On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed Caregiver G and previous Caregiver K. Caregiver G stated s/he had given Caregiver Z a drug test and it had come back negative. Caregiver G stated, "I believe that [Co-Owner B] had an issue with Caregiver Z. [S/he] was a hard worker and would always jump in and do the work that the shift prior to [him/her] had left behind. I would tell [him/her], we need to report this, and [s/he] would just take care of it." Caregiver K stated, "There were always staff members under the influence of marijuana working at the home. We would say something to [Co-Owner B] and [Licensee A] and we would just be told, 'We will take care of it.'" Caregiver K stated, "[Maintenance DD] would come in and tell them that [s/he] would go pick up staff to come to work and they would be so 'high.'"

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F (Manager/Caregiver F). Surveyor reviewed the incident regarding the cocaine found in the home. Surveyor explained that s/he was informed that Caregiver Z was scheduled to work in the home, but two staff members from the adjoining homes, kept coming into the home to utilize the bathroom. Co-Owner B stated, "That is not acceptable. They have their own bathrooms." Licensee A stated only Caregiver Z was tested, "Because the other staff said it was [Caregiver Z]." Co-Owner B stated, "[Caregiver Z] was like a

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M 230	Continued From page 24 zombie, like in a frozen mode, there was powder on the kitchen sink. [S/he] would go outside and disappear." Co-Owner B stated, "We didn't have proof." Licensee A stated, "We should have tested everybody. Not just assumed staff were telling us the truth." AED F was observed nodding his/her head in agreement. Surveyor explained his/her observations during his/her visits of smelling a strong odor of what appeared to be marijuana on staff members and being informed that the concern cannot be addressed as there is already a shortage in staff. Licensee A stated, "How do we know if they smoked marijuana prior to their shift."	M 230		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation from a physician, a registered nurse or a physician's assistant, for 1 of 2 employee files reviewed (Caregiver F), indicating that the service provider had been screened for illness detrimental to	M 232		

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M 232	Continued From page 25 residents, including tuberculosis (TB) within 90 days before the start of providing services. Findings include: On 02/01/2024, Surveyor reviewed Caregiver F's record, Caregiver F was hired from 01/10/2023 to 11/24/2023 and rehired on 01/16/2024. His/her file did not contain results from a TB screening until 07/06/2023, which was greater than 90 days since s/he had started providing services. On 02/05/2024 at 9:46 AM, Surveyor emailed Licensee A and Administration C of the concern. As of 02/12/2024 at 5:00 PM, Surveyor did not receive a response.	M 232		
M 240	88.04(4)(a) INSURANCE-VEHICLE Vehicle. An applicant for an initial license or a renewal of a license who plans to transport residents in his or her vehicle shall provide the licensing agency with a certificate of insurance documenting liability insurance. If a service provider transports residents under the direction of the licensee the service provider shall have vehicle insurance and a valid driver's license and, if requested by the licensing agency shall provide evidence to the licensing agency on 12 month intervals of a vehicle in safe operating condition on a form provided by the licensing agency.	M 240		

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M 240	Continued From page 26 This Rule is not met as evidenced by: Based on observation, record review, and interview, the home did not ensure every service provider (Caregiver S, Caregiver JJ, and Caregiver KK) transporting residents under the direction of the Licensee had current auto insurance and a safe operating vehicle. Findings include: On 01/04/2024, the Department received a concern that alleged residents were missing medical appointments due to lack of transportation. The provider is licensed to care for up to 4 residents in the client groups of: irreversible dementia/Alzheimer's disease, physically disabled, emotionally disturbed/mental illness, developmentally disabled and advanced aged. On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver S. Surveyor could overhear Caregiver S speaking with the passenger in his/her car, making comments, the brakes won't release. Surveyor asked if we should speak another time. Caregiver S stated, "Just give me a minute, I am sorry, I have a piece of [explicative word] car and I just need to give it a minute." After a moment, Caregiver S stated s/he was ready. Surveyor asked if s/he had been asked to transport residents in his/her own personal vehicles. Caregiver S stated, "Yes! [Resident 3] had been sent out to the hospital because [s/he] had broke [his/her] ankle. Of course there is a snowstorm going on and my car barely gets me from point A to point B. [Co-Owner B] stated s/he was not picking [Resident 3] up and that I had to do it. I	M 240		

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M 240	Continued From page 27	M 240		

did it!"

On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver JJ and previous Caregiver KK. Surveyor asked if they were asked to transport residents in their own personal vehicles. Caregiver KK stated, "I had been contacted by [Co-Owner B] to transport residents in my van for a community event, because the bus was broke down. I have been contacted last minute to transport residents to medical appointments because there was nobody else to take them. For instance, I drove [Resident 5] to a dentist appointment." Caregiver JJ stated, "Everybody has missed medical appointments at one time due to no transportation. We would be calling staff who weren't working to come in and take residents to appointments using their own vehicles, including myself. Management always knew what was going on." Surveyor asked who transported Resident 3 home from the hospital when s/he broke his/her ankle. Caregiver JJ stated, "[Co-Owner B] told [Caregiver S] [s/he] could go get [him/her]."

On 04/10/2024, Surveyor requested Caregiver S's, Caregiver JJ's, and Caregiver KK's proof of auto insurance while transporting residents from Licensee A and Administration C. Administration C stated that the provider's auto insurance had an endorsement that allowed staff to drive residents in their own vehicle. Administration C provided Surveyor with an insurance policy dated 09/21/2020. Surveyor asked if there was an insurance policy with this endorsement for 2022 and 2023.

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview

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M 240	Continued From page 28 with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Co-Owner B and Licensee A stated staff should not be transporting residents. Administration C stated the provider's insurance included a rider to cover staff if they did use their own vehicle. As of 04/18/2024 at 10:00 AM, Surveyor did not receive any additional documentation.	M 240		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 2 of 2 staff members (Co-Owner B and Caregiver G) received at least 8 hours, per calendar year, of continuing education training related to the health, safety, welfare, rights, and treatment of residents every year, during the calendar year 2022 and 2023. Findings include: On 05/12/2020, the provider was licensed to provide cares for up to 4 residents in the care groups: developmentally disabled, advanced	M 246		

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M 246	Continued From page 29 aged, physically disabled, irreversible dementia/Alzheimer's, and emotionally disturbed/mental illness. On 02/01/2024, Surveyor reviewed Caregiver G's record. Caregiver G was hired on 12/12/2020. Caregiver G's 2022 continuing education contained 4.5 hours of training and did not contain training related to medication administration and standard precautions. Caregiver G's 2023 continuing education contained over 8 hours of training but did not contain training related to medication administration and standard precautions. On 02/16/2024 at 9:53 AM, Surveyor emailed Licensee A and Administration C and requested Co-Owner B's continuing education for 2022 and 2023, due to his/her involvement with resident cares. On 02/19/2024 at 8:52 AM, Co-Owner B emailed Surveyor and stated, "I apologize that this has not been done before as I had thought that an owner was not under this same requirement as a caregiver." On 04/11/2024, at approximately 4:30 PM, Surveyor interviewed Co-Owner B. Co-Owner B stated, "After I think about it, I really am a caregiver with everything I do for these residents."	M 246		
M 342	88.05(4)(d)1 FIRE SAFETY EVACUATION PLAN The licensee shall have a written plan for the immediate and safe evacuation	M 342		

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M 342	Continued From page 30	M 342		

of all occupants of the home in the event of a fire. The plan shall identify an external meeting place.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not have a plan for the immediate and safe evacuation of all occupants of the home in the event of a fire.

Findings include:

This provider is licensed to care for up to 4 residents in the client groups of: irreversible dementia/Alzheimer's disease, physically disabled, emotionally disturbed/mental illness, developmentally disabled and advanced aged.

On 01/31/2024, Surveyor reviewed the providers fire drills. The fire drill, dated 12/23/2023, documented that Resident 1 and Resident 2 sheltered in place.

On 01/31/2024, 02/13/2024, 02/14/2024 and 03/06/2024, Surveyor toured the home and Resident 1 was always in his/her bed. Surveyor was informed Resident 2 passed on 01/10/2024.

On 02/05/2024, Surveyor reviewed Resident 1's and Resident 2's record.

Example 1: Resident 1

Resident 1 moved into the home, 11/14/2023, with diagnoses including Parkinson's disease with dyskinesia, muscle weakness, depression, and dystonia (a movement disorder that causes the muscles to contract involuntarily).

Resident 1's "Individual Service Plan," dated

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12/18/2023, documented:
"Evacuation: Supervise/Assist - Needs supervision /assistance to evacuate building. Provide verbal cues and physical assistance as necessary."

Resident 1's "Resident Evacuation Assessment," dated 11/15/2023, documented:
"Needs Full Assistance means the resident may require physical assistance from a staff member during most of the evacuation or the total time required for staff assistance and for the resident to evacuate the facility, is greater than the required evacuation time for the facility."
"Needs Only One Staff means there is no specific evidence that the resident needs help from two or more persons in a fire emergency."

Example 2: Resident 2

Resident 2 moved into the home, 12/21/2023, on hospice, with primary diagnosis Cri-du-chat syndrome (genetic disorder).

Resident 2's "Initial Assessment," dated 12/26/2023, documented:
"Evacuation: Supervise/Assist - Needs supervision /assistance to evacuate building. Provide verbal cues and physical assistance as necessary. Staff 2 Person assist."

On 03/09/2024 at 7:02 AM, Surveyor emailed Licensee A and Administration C and requested the provider's fire evacuation plan.

As of 03/18/2024 at 10:02 AM, Surveyor received an email from Administration C. Administration C provided Resident 7's "Fire Evacuation Plan," which documented:
"When the fire alarm is activated, 911 will be

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M 342	Continued From page 32 called and the fire reported. All residents should exit the residence through the nearest and safest exit of the home. A drawing of the exiting plan is posted on the wall. On duty staff will supervise all residents to the designated meeting place. ..." Surveyor noted Resident 7 resided in one of the adjoining homes. On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Surveyor discussed the concerns regarding residents being a point-of-rescue in an adult family home. Surveyor did not receive a response.	M 342		
M 406	88.06(3)(b) PERSONS INVOLVED WITH ISP & ASSESSMENT The individual service plan and written assessment shall be developed by the placing agency, if any, the service coordinator, if any, the licensee, the resident and the resident's guardian, if any and designated representative, if any, with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the Individual Service Plan (ISP) for 1 of 3 records (Resident 5) reviewed was developed together with the placing agency, the resident representative, and the	M 406		

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M 406	Continued From page 33 provider. Findings include: On 03/05/2024, Surveyor reviewed Resident 5's record. Resident 5 moved into the home, 11/06/2020, and had a managed care organization (MCO) Care Manager (CM), currently CM GG. Resident 5's record contained an ISP, dated 12/07/2023, which was not signed and dated by an MCO CM. On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Licensee A and AED F stated that signatures would be captured by all individuals during the resident's care conference meetings.	M 406		
M 408	88.06(3)(c) ASSESSMENT IDENTIFY NEEDS & ABILITIES The assessment shall identify the person's needs and abilities in at least the areas of activities of daily living, medications, health, level of supervision required in the home and community, vocational, recreational, social and transportation. This Rule is not met as evidenced by:	M 408		

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M 408	Continued From page 34 Based on observation, record review, and interview, the provider did not ensure 1 of 1 resident was assessed to identify his/her needs in the areas of activities of daily living and health in the home. Resident 1 had 1/2-size side rails up on both sides of his/her bed. The provider had used these potentially dangerous devices without any assessment of the need or purpose, the potential for injury, whether the devices meet the definition of a restraint, and no exploration of alternatives to the side rails. In addition, the provider had not applied for a waiver of the code prohibiting the use of a restraint. Findings include: "Potential Risks of Bed Rails 1. Create a source of known morbidity and mortality such as: o Strangling, suffocation, serious bodily injury,* or death when patients or parts of their bodies are caught between rails, the openings of the rails, or between the bed rails and mattress. 2. Impede patients from safely getting out of bed: o Patients crawl over rails and fall from greater heights increasing the risk for serious injury. o Patients attempt to get out of bed over the foot board. 3. Restrain patients in many circumstances: o Hinder patients from independently getting out of bed thereby confining them to their beds. o Create a barrier to performing routine activities such as going to the bathroom. 4. Can create negative psychological effects: o Create undignified personal image. o Alter patient self-esteem. o Contribute to patient isolation. o Confinement can cause patients to be incontinent. The potential risks can be exacerbated by: o Improper match of the bed rail to bed frame. o Improper installation. o Objects	M 408		

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such as holders or supports that remain when the bed rail is removed." (Source: DHS website, Assisted Living and Adult Day Care Centers: Standards of Practice Resources, April 2003, https://www.dhs.wisconsin.gov/regulations/assisted-living/standards.htm (retrieval date - April 11, 2024).)

On 03/06/2024, at approximately 2:10 PM, Surveyor observed Resident 1 in his/her bed. Resident 1 stated to Surveyor that s/he could not reach his/her call light and attempted to reach for it. Surveyor noted the call light was tightly wrapped around the bed rail, hanging on the outside of the bed rail, with Resident 1 having to reach at shoulder height to reach the call light. Resident 1 stated, "It isn't like they would respond anyways."

On 03/06/2024, Surveyor reviewed Resident 1's record.

Resident 1 admitted to the home, 11/14/2023, with diagnoses including Parkinson's disease with dyskinesia, dystonia, muscle weakness, muscle spasm, and depression. Resident 1 was on hospice.

Resident 1's pre-admission paperwork documented:
10/20/2023 - Rehab Progress Notes - Patient states s/he is unable to move when s/he wakes up in the morning due to stiff muscles over bilateral lower and upper extremities.

Resident 1's "Hospice Team Visit Communication," dated 11/28/2023, documented: "Admit into Hospice care"

Resident 1's "Observations" documented:

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M 408	Continued From page 36 11/15/2023 - Writer observed resident have muscle spasms. Resident is noted to have episodes that residents' muscles stiffen up and resident cannot move. 11/17/2023 - Resident is really sad and depressed [s/he] told both staff members that [s/he] would rather be in the lord's hands, and [s/he] wants [his/her] [daughters/sons] to have peace and for them not to worry about [him/her]. 11/30/2023 - Had a freezing episode around 7:40 PM. 12/06/2023 - Writer spoke to care staff. Care staff stated resident had [his/her] T-shirt wrapped around the side rail, over [his/her] body and around [his/her] neck as if [s/he] was trying to coke [sic: choke] [him/herself]. Care staff stated that when [s/he] tried to get resident to release the shirt [s/he] hesitated and refused momentarily. Care staff immediately went to get management. Management came down from office to assess the resident. When management questioned the resident if [s/he] tried to choke [him/herself] resident stated that "[S/he] doesn't know." Writer reached out to hospice to advise. As writer called hospice, resident then tried to throw [him/herself] on the floor. Care staff was able to stop [him/her] from falling on the floor. When writer asked resident if [s/he] tried to fall on purpose to inflict harm on [him/herself] resident stated, "Yes." Hospice advised writer to send resident to hospital. Owner wanted hospice to come out and evaluate resident prior to sending [him/her] to hospital. Writer awaiting hospice to arrive. Owner aware. 12/06/2023 9:15 PM -Resident is being transferred to [hospital] for mental health evaluation. 12/07/2023 3:15 PM -Writer spoke to [hospital]. Hospital stated resident was admitted around 1AM today.	M 408		

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M 408	Continued From page 37 Resident 1's hospice "Medical Practitioner's Orders," dated 12/14/2023, documented: "Pt (patient) is having difficulty with expressing needs cannot reach call light or bed adjustment." Resident 1's "Individual Service Plan," dated 12/18/2023, documented: "Supervision: Needs some supervision" "Capacity for Self Care: Needs some assistance" "Capacity for Self Direction: Makes needs known" "Attitude: Displays positive/appropriate attitude and requires no assistance" On 03/06/2024, Surveyor reviewed previous interviews conducted: On 03/02/2024, at approximately 10:35 AM, Surveyor interviewed previous Caregiver O. Caregiver O stated, "Once [s/he] tried to commit suicide, they keep [his/her] door closed. They don't think [s/he] can move but [s/he] can; you have to take [his/her] hands and make sure they aren't tucked under [his/her] body." On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Caregiver W stated Resident 1 had no muscle strength. Surveyor noted Resident 1's record did not contain a bedrail assessment. On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Co-Owner B stated, "We are keeping [his/her] bed low to the ground, so that [s/he] cannot hang [him/herself] from the bedrail." Licensee A asked if hospice would have completed the assessment.	M 408		

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M 410	Continued From page 38	M 410		
M 410	88.06(3)(d) INDIVIDUAL SERVICE PLAN The individual service plan shall contain at least the following: This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the Individual Service Plan (ISP) for 2 of 3 residents accurately identified current needs and abilities. Current census was 3. Resident 1's ISP did not identify that s/he had suicidal tendencies, refused medication administration, expressed signs of depression, and refused food. Resident 3's ISP did not identify that s/he was a fall risk and an elopement risk or his/her required supervision levels. Findings include: On 05/12/2020, the provider was licensed to provide cares for up to 4 residents in the care groups: developmentally disabled, advanced aged, physically disabled, irreversible dementia/Alzheimer's, and emotionally disturbed/mental illness. Example 1: Resident 1 On 01/31/2024, at approximately 11:50 AM, Surveyor observed staff communicating that Resident 1 had refused his/her medications.	M 410		

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BETTES PLACE I	1515 A HIGHWAY 175 RICHFIELD, WI 53076

(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
M 410	Continued From page 39 Surveyor observed Resident 1 lying in his/her bed. On 01/31/2024, at approximately 12:05 PM, Surveyor interviewed Hospice Registered Nurse (RN) K, who was sitting at the table completing his/her notes. RN K informed Surveyor that Resident 1 refused his/her medications often and s/he often refused to eat. RN K stated, "A staff member just informed me that s/he was able to get [him/her] to eat some applesauce, so that is good." On 01/31/2024, Surveyor reviewed Resident 1's record. Resident 1 moved into the home, 11/14/2023, with diagnoses including Parkinson's disease with dyskinesia, muscle weakness, depression, and dystonia (a movement disorder that causes the muscles to contract involuntarily). Resident 1's "Observations," dated 11/15/2023 through 01/31/2024, documented: 11/15/2023 - Refused to eat lunch. Resident refused to eat throughout shift. At 8pm med pass, writer successful in getting resident to drink about 8 ounces of water. Offered other fluids, but resident refused everything but water. Resident is noted to have episodes that residents' muscles stiffen up and resident cannot move. 11/16/2023 - Resident continues to refuse meals. 11/17/2023 - Resident continues to refuse meals. Resident is really sad and depressed. Told staff members that s/he would rather be in the lords' hands. 11/18/2023 - Resident continues to refuse meals. Resident upon start of shift in frozen position. About forty-five minutes later, cramps settled down. At about 8:30 pm another episode of	M 410		

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tremors and cramping.
11/19/2023 - Resident continues to refuse meals.
11/20/2023 - Resident continues to refuse meals.
11/21/2023 - Resident continues to refuse meals.
11/26/2023 - Refused his/her 4am medications. Keeps talking about dying and returning home back with the lord. Writer stayed with Resident 1 all night. Resident would like to be placed on hospice.
11/30/2023 - Hospice stated oxygen will be delivered today.
12/06/2023 - Care staff stated resident had his/her t-shirt wrapped around the side rail, over his/her body and around his/her neck as if [s/he] was trying to choke him/herself.
12/13/2023 - Resident declined all food offered throughout shift. ... Resident feared choking throughout shift.
12/15/2023 - For fear of choking, offered meals throughout shift patient declined
12/16/2023 - Resident fears choking on [his/her] saliva. [S/he] was jumpy because [s/he] keeps seeing bats.
12/21/2023 - Resident refused [his/her] 8pm Quetiapine. Does not want to take it at all anymore.
12/22/2023 - Resident "frozen" most of night. Resident wanted one on one time with writer constantly.
12/23/2023 - Resident feels like his/her psychotropic is not working. S/he wants to stop taking this medication. [S/he] feels the medication is making his/her paranoia worse.
12/24/2023 - Resident refused lunch and meds.
12/25/2023 - Refused one of his/her 4pm meds.
12/29/2023 - Continues to think that psychotropic is making him/her worse and refused this medication.
12/30/2023 - Refused the Seroquel.
12/31/2023 - Refused the Quetiapine

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01/03/2024 - Resident stated s/he is hallucinating a lot.
01/04/2024 - Resident states his/her hallucinations are getting worse.
01/08/2024 - Resident refused breakfast
01/09/2024 - Acting very confused about what s/he wants or needs from staff
01/10/2024 - Came out to eat breakfast and refused to eat. Refused lunch.
01/13/2024 - Meds were in the resident's mouth and then s/he spit them out.
01/15/2024 - Refused to eat lunch. Spoke about "not being here much longer"
01/19/2024 - Resident refused all food today. Resident made him/herself throw up and played with his/her spit, making spit bubbles.
01/21/2024 - Resident refused breakfast and lunch. Refused to eat supper.
01/31/2024 - Refused all medications.

Resident 1's November 2023, December 2023, and January 2024 Medication Administration Record documented consistent medication refusals.

Resident 1's "Individual Service Plan," dated 12/18/2023, documented:
"Eating - Requires no assistance with eating meals. Resident requires soft food."
"Snack Monitor - Monitor and document food intake outside of scheduled meal times as it occurs."
"Special Dietary Needs - Monitor and assist with special dietary needs."
"Medication Management - Staff Administer: Show package, show meds being put in applesauce in front of [Resident 1]."
"Pain History - Resident has pain and stiffness in upper and lower extremities. Resident is taking muscle relaxers and daily Range of Motion

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(ROM) for pain management."
"Attitude - Displays positive/appropriate attitude and requires no assistance."
"Interactions - Displays positive/appropriate interaction with others and requires no assistance."

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Surveyor discussed concern regarding ISP individualization. Licensee A asked, "Do you think [Resident 1] will try to commit suicide again." Co-Owner B stated, "Absolutely should be in the ISP. [S/he] tied [his/her] t-shirt around [his/her] bedpost." AED F also explained the ISP requirements with Licensee A and Co-Owner B. AED F stated s/he would review all resident ISPs.

Example 2: Resident 3

Resident 3 moved into the home, 09/10/2020, with diagnoses including Stage 4 chronic kidney disease, chronic pain, seizure disorder, and brain aneurism.

Resident 3's "Observations," dated 06/03/2023 to 01/25/2024, documented:
"06/03/2023 - Resident started walking outside by [him/herself] without [his/her] walker or wheelchair."
"09/17/2023 - [Resident 3] needs to be walked with at all times especially to the bathroom, [s/he] is falling often."
"10/11/2023 - Kept getting up from the table without [his/her] walker walking around was redirected that [s/he] needs to use [his/her] walker at all times when [s/he] is transferring or walking that the walker is used for [his/her]

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safety."
"10/23/2023 - Keeps walking around without [his/her] walker."
"11/09/2023 - Reached out to [POA (power of attorney) AA] to update [him/her] about the fall today."
"11/11/2023 - Kept walking around without [his/her] walker."
"11/15/2023 - Numerous times during shift, resident would walk without walker, pick up items off the floor or try to walk unattended. Reminders to resident to let staff help [him/her]. Resident would yell back at other resident when [s/he] would yell out/have behaviors."
"11/18/2023 - Four reminders to resident to use walker and two reminders not to bend over to pick things up from floor."
"11/27/2023 - Resident needed constant reminders to use walker when walking and to not bend down to pick up items off floor."
"11/30/2023 - Resident continues to walk without walker most times and bends over or reaches for things when [s/he] can't balance [him/herself] properly."
"12/03/2023 - Resident had unwitnessed fall at approximately 7:40 pm."
"12/05/2023 - Keeps getting up without [his/her] walker."'
"12/06/2023 - Resident continues to walk without walker and bend over without walker or tries to pick up items off floor without walker."
"12/19/2023 - Resident continues to walk or bend down without walker."
"12/21/2023 - Resident continues to walk without walker constantly even after cueing."
"12/22/2023 - Resident continues to bend over without balance and walking without walker. Resident came out of room at 9:25pm stating [s/he] fell by bed."
"12/28/2023 - Very aggressive with not listening

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and following directions, constant redirection of the proper way to use [his/her] walker."
"12/30/2023 - Resident continues to leave walker outside bathroom door as well as not using walker when walking to kitchen sink."
"01/08/2024 - Resident continues to walk without walker and bend over to pick items off floor without asking for help."
"01/09/2024 - Resident continues to walk without walker."
"01/11/2024 - Keeps walking around without [his/her] walker, get very upset when staffs redirect [him/her] to use [his/her] walker."
"01/16/2024 - Had a slip and fall this morning trying to carry [his/her] cups and walk towards the counter for breakfast."
"01/25/2024 - Resident had a fall trying to find the heart monitor charger in [his/her] room."

Resident 3's "Incident Reports" documented:
09/14/2023 - I heard a loud boom and turned around and [Resident 3] was on the floor and the legs on the chair were broken.
10/25/2023 - Resident fell in sitting position on the floor next to bed.
11/09/2023 - At 11am today staff heard a bang and [Resident 3] was on the bathroom floor on [his/her] buttocks.
12/03/2023 - Staff coming out of [resident] room and saw resident on floor on buttocks. Resident states [s/he] slid down slowly.
12/22/2023 - Resident came out of bedroom to kitchen where writer was working and told writer [s/he] fell by bed corner and [his/her] right wrist hurts.
12/30/2023 - Spilled water on [him/herself] and attempted to stand from chair too fast when [s/he] fell.
01/07/2024 - Resident lost balance in shower area. Trying to turn around so caregiver could

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wash [his/her] back.
01/25/2024 - Resident was found in sitting position on the floor next to bed.

Resident 3's "ISP," dated 12/05/2023, documented:
"Mobility and Transferring: 1 person required for this task - Provide full assistance."
The ISP did not identify Resident 3 was a fall risk and/or non-complaint with his/her walker.

On 02/24/2024, at approximately 5:15 PM, Surveyor interviewed Caregiver EE. Caregiver EE explained, "[Resident 3] has fallen so many times, because [s/he] doesn't use [his/her] walker; [s/he] really thinks [s/he] can walk without it. [His/Her] falls are not always recorded because [s/he] falls so many times. I started 01/06/2024 and I know [s/he] has fallen at least four times. [Resident 3] has had 5 or 6 falls that are not documented. [Licensee A] will say they just slid out of their chair, so it doesn't have to be recorded."

On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Manager N stated Resident 3 was a fall risk. Manager N stated, "Incident reports were not filed properly. There would be times I was progress noting and [Licensee A] would tell me I am only to write a progress note if [s/he] has cleared it. I would explain that I understand what needs to be written in a progress note and s/he would go around me and delete my progress notes."

On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Caregiver W stated, "[Resident 3] has to be constantly redirected. [S/he] doesn't want to use [his/her] walker. [S/he] thinks [s/he] doesn't need it."

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M 410	Continued From page 46 Caregiver W stated, "They don't document anything here, they don't do incident reports. They want to hide everything." On 03/10/2024, at approximately 12:10 PM, Surveyor interviewed Resident 3's Family Member AA. Family Member AA stated Resident 3 does not want to use his/her walker, which resulted in him/her sustaining numerous falls. On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver S. Caregiver S stated Resident 3 was always falling. Caregiver S stated, "We were told not to write a progress note for every time [Resident 3] fell. Even if we did make a note, it probably wouldn't be there the next day because management would delete it." On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed Caregiver JJ and Caregiver KK. Caregiver JJ stated, "[Resident 3] has had broken ribs, broken ankle, a broken toe. This would be documented but the reports never stayed in the system." On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and AED F. Surveyor discussed concern regarding ISP individualization. AED F also explained the ISP requirements with Licensee A and Co-Owner B. AED F stated s/he would review all resident ISPs. Cross Reference: M0580 DHS 88.10(3)(p) Prompt and Adequate Treatment	M 410		

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M 414	88.06(3)(d)2 LEVEL OF SUPERVISION Identification of the level of supervision required in the home and community. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 (Resident 3) individual service plans (ISP) reviewed contained the level of supervision required in the home and community. Findings include: On 02/14/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver CC. Caregiver CC stated the home was to have two staff members, but it rarely happened. Caregiver CC stated, "We have two residents that are elopement risks and then you have one person trying to watch them, plus a hospice patient!" On 02/24/2024, at approximately 5:15 PM, Surveyor interviewed Caregiver EE. Caregiver EE stated, "We are always short staffed. If I am in the bathroom, say with [Resident 5], and [Resident 3] decided to leave the home, there is not much I can do." On 03/01/2024, at approximately 11:50 AM. Surveyor interviewed previous Caregiver M. Caregiver M stated, "[Resident 3] is always trying to escape. [S/he] wants to go home." Caregiver M stated, "The homes are always understaffed and when you are in [Home Name] by yourself, and [Resident 3] wants to leave, it is difficult."	M 414		

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M 414	Continued From page 48 On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Manager N stated Resident 3 was an elopement risk. Manager N stated, "[Resident 3] was always trying to leave, as soon as [s/he] knew you were busy with another resident, [s/he] would try to leave, [s/he] will not wait for you. [S/he] knows when you are assisting another resident and then [s/he] will leave the building." Manager N stated, "Incident reports were not filed properly." On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Caregiver W stated all the residents in the home were an elopement risk. Caregiver W stated, "They don't document anything here, they don't do incident reports. They want to hide everything." On 03/05/2024, Surveyor reviewed Resident 3's record. Resident 3 moved into the home, 09/10/2020, with diagnoses including Stage 4 chronic kidney disease, chronic pain, seizure disorder, and brain aneurism. Resident 3's ISPs, dated 06/01/2023 and 12/05/2023, documented: "Wandering Risk" - No comments "Elopement Risk" - No comments "Mental Health - Requires staff assistance and encouragement maintaining appropriate/positive attitudes." Resident 1's ISP did not identify level of supervision required in the home and community. Resident 3's "Observations," dated 06/01/2023 to 01/31/2024, did not document that Resident 3 had attempted to elope from the home.	M 414		

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M 414	Continued From page 49 On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed Caregiver JJ and Caregiver KK. Caregiver JJ stated, "[Resident 3] has had broken ribs, broken ankle, a broken toe. This would be documented but the reports never stayed in the system. If [s/he] left the home, that would never be reported/documented." On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Surveyor explained that each resident required supervision levels to be detailed in their ISP. AED F stated s/he would review each resident's ISP and update accordingly. Cross Reference: 88.06(3)(d) Individual Service Plan	M 414		
M 430	88.07(1)(c) ACTIVITIES AND SERVICES The licensee shall plan activities and services with the residents to accommodate individual resident needs and preferences and shall provide opportunities for each resident to participate in cultural, religious, political, social and intellectual activities within the home and community. A resident may not be compelled to participate in these activities. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure activities and services were planned for 3 of the 3 residents who reside in the home, which would accommodate individual	M 430		

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resident needs and preferences.

Findings include:

On 02/02/2024, the Department received a concern alleging activities are not provided to residents.

On 01/31/2024, from approximately 10:00 AM to 2:45 PM, on 02/13/2024, from approximately 12:30 PM to 5:30 PM, and on 02/14/2024, from approximately 9:15 AM to 3:30 PM, while onsite, Surveyor did not observe any postings about resident activities or observe any group activities.

On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Caregiver I stated, "[Resident 6's POA (POA Z)] wanted [Resident 6] to have more outside activities, so I watched [Co-Owner B] put [him/her] in the van and send a picture to [POA Z] to show they were on an activity, but they were just in the parking lot."

On 02/25/2024, at approximately 9:50 AM, Surveyor interviewed previous Caregiver J. Caregiver J stated the only activities the owners scheduled "were activities related to holiday activities, birthdays, football party, sometimes take them to the other houses; no day-to-day activities on second shift. Then residents do things to "create attention." Caregiver J stated that s/he felt resident negative behaviors were due to "boredom." Caregiver J stated, "We were always short staffed, so residents who are more independent are expected to entertain themselves."

On 02/25/2024, at approximately 10:35 AM, Surveyor interviewed Resident 5's Power of

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Attorney (POA) Y. POA Y stated, "There are no activities, [Resident 5] is always "lonely." Staff are always sitting on their phones, not engaged with the residents. I will be there, and staff and management are sitting at the table talking about personal items, playing on their phone; nobody is paying attention to the residents. I must ask several times so that someone will assist [Resident 5] in the bathroom. I received a call twice on Friday (02/23/2024) that staff couldn't calm [him/her] down. I am on the phone with [Resident 5] and [s/he] kept saying [s/he] was lonely." POA Y stated, "Staff will focus on cleaning, instead of interacting with the residents. Why can't they do cleaning during the night shift?"

On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Caregiver M stated there was never enough staff. Caregiver M stated, "Management expects one person to be able to care for hospice patients and two residents who are always wanting to leave the building, let alone arrange activities with the residents."

On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Manager N stated, "I have never seen a building not have activities at all. They rely on family members to come in and do activities with the residents. Staff did not do activities with residents." Manager N stated, "There was never enough staff in the home."

On 03/02/2024, at approximately 10:35 AM, Surveyor interviewed previous Caregiver O. Caregiver O stated the owners would have a person come in to do activities with the residents, "I think once a week." Resident 3 and Resident 5 would color in their crossword books, which were

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provided by POA Y.

On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Caregiver W stated, "There was an activity person, but you never knew when [s/he] would show up and if [s/he] did show up, would [s/he] actually do an activity with the residents. There is no activity board and management does not tell us what we should do." Caregiver W stated, "When you were here on Valentine's Day, that was all show, the owners never buy Valentine's stuff for the residents. They rely on family members to do that. When us staff want to get balloons or a cake or something for a resident's birthday, we are told that is too expensive."

On 03/06/2024, at approximately 12:30 PM, Surveyor arrived at the home to find POA Y and Resident 5 playing a game of Yahtzee in the community room.

On 03/08/2024, at approximately 10:50 AM, Surveyor interviewed Caregiver V. Caregiver V stated, "They took [his/her] (the activity staff) hours, [s/he] was supposed to do activities on Thursdays."

On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver S. Caregiver S stated, "We often did not have an activity person and activities were not directed towards the individuality of the resident."

On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver JJ and previous Caregiver KK. Caregiver JJ and Caregiver explained that the individuals hired to oversee activities, were not aware of the different diagnoses that the residents had, so often

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M 430	Continued From page 53 activities were not individualized to address all residents. The activity staff would work with those staff members who did not display any behaviors or limitations. Caregiver JJ and Caregiver KK stated, "[POA Y] would be the one that would do activities with the residents. [S/he] would take them to the community room and interact with them. Do games, bring snacks, etc." Surveyor observed this on 01/31/2024, 03/06/2024, and 04/11/2024. On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Co-Owner B stated an activity board was now being utilized. Co-Owner B stated, "For example, we now are doing exercises at 9:30 in the morning." Co-Owner B, Licensee A, Administration C and AED F communicated amongst themselves identifying that resident behaviors could have been due to lack of activities.	M 430		
M 444	88.07(2)(b)3 TRANSPORTATION TO MEDICAL Providing, arranging, transporting or accompanying a resident to medical or other appointments as part of the resident's individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide or arrange for transportation and/or accompany 2 of 2 residents (Resident 3 and Resident 5) to their medical appointments. Findings include:	M 444		

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M 444	Continued From page 54 On 02/02/2024, the Department received a concern alleging residents missed medical appointments due to transportation not being scheduled. The provider is licensed to care for up to 4 residents in the client groups of: irreversible dementia/Alzheimer's disease, physically disabled, emotionally disturbed/mental illness, developmentally disabled and advanced aged. Example 1: Resident 3 On 03/02/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver L. Caregiver L stated Resident 3 had missed an eye appointment and a dentist appointment. Caregiver L stated, "I do not remember if it was because there was no transportation available or if there was no staff available to assist [him/her] during [his/her] appointment." Caregiver L stated Licensee A or Co-Owner B were responsible for arranging these services. On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Caregiver W stated Resident 3 had missed doctor appointments because Licensee A had not scheduled the transportation in a timely manner. On 03/06/2024, at approximately 3:35 PM, Surveyor interviewed Licensee A. Licensee A stated residents had not missed any medical appointments. On 03/08/2024, at approximately 10:45 AM, Surveyor interviewed Caregiver V. Caregiver V stated, "[Resident 3] missed a medical appointment. I think it had to do with [his/her]	M 444		

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M 444	Continued From page 55 ankle." On 03/10/2024, at approximately 12:10 PM, Surveyor interviewed Resident 3's Family Member (FM) AA. FM AA stated, "I do not know if [s/he] has missed any medical appointments. The [provider] has not said anything to me regarding that. I let the provider take over that for [Resident 3]. [S/he] cannot make [his/her] appointments or arrange transportation due to [his/her] memory capability. [S/he] needs assistance on all ends. [S/he] has no short-term memory." On 03/10/2024, Surveyor reviewed Resident 3's record. Resident 3's "Individual Service Plan," dated 12/05/2023, documented: "Transportation - Independent: Maintain independence and receive transportation to desired locations." "Destructive/Abuse: Requires supervision and monitoring to help manage/redirect destructive/abusive behaviors." Resident 3's "After Visit Summary," dated 05/21/2023, which listed upcoming appointments, had a handwritten note on it that stated the 06/02/2023 physical therapy appointment was missed. On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed Caregiver S. Caregiver S stated Resident 3 had missed medical appointments. Resident 3 did not have family members to assist, so it was the providers responsibility. Example 2: Resident 5	M 444		

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M 444	Continued From page 56 On 02/26/2024, at approximately 12:30 PM, Surveyor interviewed Resident 5's managed care organization (MCO) Care Manager GG. MCO GG stated it had been reported that the provider would cancel appointments if Resident 5's POA Y was unable to take [him/her] to the appointment or if POA Y was not able to meet Resident 5 at a medical appointment. MCO GG stated it had been discussed with Licensee A that they are responsible for arranging transportation and assisting the resident during the appointment, if necessary. Surveyor requested Resident 5's MCO documentation. On 03/06/2024, at approximately 3:35 PM, Surveyor interviewed Licensee A. Licensee A stated residents had not missed any medical appointments. On 03/06/2024, at approximately 5:10 PM, Surveyor interviewed POA Y. POA Y stated, "I was very frustrated. [Licensee A] was supposed to attend a meeting with [Resident 5] yesterday but supposedly "missed" the shuttle and could not make it. Sometimes I cannot make it to the appointments, and I need someone there who knows [Resident 5]." On 03/08/2024, Surveyor reviewed Resident 5's record. Resident 5's MCO documentation, dated 11/15/2023, stated: "Transportation: Member needs an attendant with him/her for transportation. Family/caregiver/friends are available to assist with transportation; Needs assistance with finding/arranging transportation."	M 444		

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M 444	Continued From page 57 On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Licensee A stated, "Sometimes we are not aware of the appointments because family makes the appointments." Co-Owner B stated, "We do miss medical appointments and yes, staff should be staying with the resident during the appointment. [Resident 3] is a fall risk." AED F stated that a calendar was going to be utilized so that management would be able to track resident medical appointments and ensure transportation and assistance was provided.	M 444		
M 448	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary. This Rule is not met as evidenced by: Based on record review and interview, the provider did not monitor 2 of 2 resident's health. Resident 3 experienced significant weight gain which was not monitored by the provider. Resident 4 was hospitalized due to septic shock due to pneumonia versus UTI (urinary tract infection) and acute hypoxic respiratory failure which was not monitored by the provider. Findings include: On 01/04/2024, the Department received a concern that alleged resident's health was not	M 448		

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properly monitored.

Example 1: Resident 3

On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Caregiver W stated, "[Resident 3] has gained so much weight. [His/her] doctor been asking about [him/her] getting smaller portions, low sodium diet, but we didn't know. I found out because I went with [him/her] to a doctor appointment. [S/he] is supposed to drink de-caf coffee, one cup a day. I did not know, [s/he] drinks coffee all day, regular coffee."

On 03/10/2024, at approximately 3:10 PM, Surveyor interviewed Resident 3's Family Member (FM) AA. FM AA stated s/he had concerns regarding how the provider was monitoring Resident 3's health as s/he had gained "a lot of weight." FM AA stated, "I am told [s/he] doesn't remember [s/he] has eaten but who is monitoring [her/him]. Shouldn't they be monitoring when [s/he] has eaten? How much [s/he] has eaten? How to redirect [him/her]? [S/he] has short-term memory issues."

On 03/10/2024, Surveyor reviewed Resident 3's record.

Resident 3 moved into the home, 09/10/2020, with diagnoses including anemia in Stage 4 chronic kidney disease, gastritis, polycystic kidney (development of cysts in the kidneys), brain aneurism, and seizure disorder due to stroke."

Resident 3's "Individual Service Plan (ISP)," dated 12/05/2023, documented:
"Eating - Independent: [Resident 3] eats very

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slowly. [S/he] is easily distracted. Staff needs to remind [Resident 3] to keep eating. Staff also need to watch to make sure [s/he] does not give [his/her] food to other residents." Staff will monitor [Resident 3] for any changes. Staff will document and report any changes to the manager and the supervising manager. The goal is for [Resident 3] to eat 3 nutritional meals and snacks."
"Eating - Food Consumption: Assistance required in eating meals. Staff to document consumption monitoring per meal. Doctors indicated that [Resident 3's] weight gain need to be monitored. Portion control should be encouraged. [S/he] needs to be redirected when [s/he] requests 2nds or if [s/he] forgets that [s/he] already ate."
"Attitude - Staff Assist/Encourage: Provide assistance maintaining positive attitude. Provide encouragement and redirect negative attitudes."
The ISP does not document that Resident 3 forgets that s/he had eaten and how to redirect and suffered from short-term memory loss.

Resident 3's "Observation" notes, dated December 2023 and January 2024, documented:
12/25/2023 - Ate 100% of meals, 100% of [his/her] snacks.
12/27/2023 - Ate a whole case of cookies.
12/28/2023 - Took hours eating [his/her] food today.
01/13/2024 - Had dinner that was fish sticks, fries, and applesauce. [S/he] ate good.
01/15/2024 - Had dinner which was shrimp stir fry and for dessert [s/he] had cake and ice cream for a resident's birthday.
Surveyor noted staff documented Resident 3's food consumption 5 times between 12/05/2023 and 01/30/2024.

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M 448	Continued From page 60 Resident 3's "Vital History" documented the following weights: 02/22/2023 - 170 pounds 10/11/2023 - 199 pounds 01/02/2024 - 210 pounds 03/07/2024 - 205 pounds Resident 3's medical documents stated: "01/23/2024 - Today's Visit: Weight Gain" On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver S. Caregiver S stated, "[Resident 3] gained so much weight. [S/he] would not stop eating. [S/he] would come out and eat breakfast, then another resident would come out and want breakfast and [Resident 3] would state I am ready for breakfast, even though [s/he] had just eaten. [His/Her] short-term memory was awful. Staff would need to re-direct [him/her] but I would see staff just let [him/her] have another plate of food, so they would not have to deal with any potential behaviors." On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver JJ and previous Caregiver KK. Caregiver JJ stated, "[Resident 3] had such short-term memory loss and [s/he] wouldn't remember eating." On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Surveyor discussed the lack of documentation to show that Resident 3's weight had been monitored. AED F stated s/he had increased his/her documenting in resident observation notes.	M 448		

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Example 2: Resident 4

On 02/20/2024, Surveyor reviewed Resident 4's record.

Resident 4 moved into the home, 10/04/2021, with diagnoses including down's syndrome, achalasia of cardia (swallowing disorder), joint disorder, and cardiac bi-ventricular pacemaker placement.

Resident 4 was placed on hospice 07/28/2023.

Resident 4's medical record, dated 07/06/2023, documented:
"[Resident 4] ... admitted to [hospital] on 07/05/2023 with difficulty breathing and low blood pressure ... Per EMR, family was visiting and noted difficulty breathing ... [S/He] was on hospice prior to admission and the hospice RN was present. Family requested that hospice be revoked. ... Active issues this hospitalization: Septic shock due to pneumonia vs UTI, acute hypoxic respiratory failure, hypoglycemia and elevated troponin"
"Palliative Care IP Daily Progress Note," dated 07/24/2023, documented:
"[Resident 4], with Down's syndrome, achalasia, and complete heart block s/p pacemaker who was admitted with septic shock due to pneumonia versus UTI and acute hypoxic respiratory failure."

Resident 4's "Observation" notes did not have any documented observations between 06/02/2023 until 07/05/2023 at 7:00 PM.
"07/08/2023 7:00 PM: Resident ate breakfast in the morning and had seconds. [S/he] sat outside for lunch but [sic] did want to eat and [s/he] said [s/he] wanted to lay down for awhile because [s/he] was tired. Staff gave [him/her] some juice

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and [s/he] had a hard time drinking it. Staff went in by resident around 2PM to see if [s/he] wanted to get up and [s/he] stated [s/he] just wanted to stay in bed. Staff changed [him/her] and gave [him/her] more to drink. Staff tried to get resident up around 6PM and resident was still tired and started to cough and was yelling out. Staff called lead and asked what to do and lead told staff to give resident a lorazepam and to call hospice. Hospice didn't pick up right away, so staff left message. In the meantime, guardian came to drop off some shoes and [Resident 4] told [him/her] that [s/he] wanted to go to the hospital. ..."
"07/06/2023 2:15 PM: Still in ICU and that [s/he] will be there for awhile and that [s/he] has a lot of support and family around [him/her]."

Resident 4's "Annual Assessment," dated 04/11/2023, documented:
"Physical Health: Chronic Illness, Short Term Illness, and Recurring Illness"
No guidelines were defined.
"Nursing Procedures"
No guidelines were defined.
"Psychotropic Medication"
No guidelines were defined.
Surveyor noted the assessment did not define Resident 4's baseline and/or provide guidelines for his/her care.
Surveyor noted the assessment did not identify the resident was under hospice cares.

On 03/11/2024, Surveyor requested and reviewed Resident 4's managed care organization record which documented:
"07/10/2023 - member was admitted to [hospital] last week on 07/05 for UTI, C-Diff, and pneumonia."
"07/11/2023 - member's family was visiting with

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M 448	Continued From page 63 [him/her] and [s/he] was struggling with breathing, the hospice RN was present and gave member some Ativan. Member's family revoked [his/her] DNR (do-not-resuscitate) status and hospice and had [him/her] admitted to the hospital. Member is currently in the ICU weaning off pressors and O2 (oxygen), but continues on the BiPap. ... Member's UA (urinary analysis) was positive for nitrates and C-diff was negative." "07/17/2023 - Updated that member is out of the ICU and in the MCU which is a step down unit, member is still really sick and is currently on a pureed diet with nectar thickened liquids ..." "07/28/2023 - Member discharged back to [AFH]" On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and AED F. Surveyor discussed the lack of documentation to show that Resident 4's health symptoms had been monitored. AED F stated s/he had increased his/her documenting in resident observation notes.	M 448		
M 462	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician.	M 462		

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M 462	Continued From page 64 This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure that 3 of 3 residents received the correct dosage of medication at the correct time and followed physician guidelines. Resident 1's Baclofen, Carbidopa-Levodopa, Citalopram, Meloxicam, Tamsulosin, Polyethylene, Quetiapine Fumarate, Senna-Docusate were not available for administration. Resident 4's PRN (as needed) Morphine was not available for administration. Resident 6's Benzoyl Peroxide Findings include: On 10/04/2023, the Department received a concern that errors were being made in residents medication administration and the availability of medication. Example 1: Resident 1 On 02/13/2024, at approximately 1:00 PM, Surveyor interviewed hospice Registered Nurse K. Surveyor asked if there were concerns with medication availability for Resident 1. Registered Nurse K stated the Surveyor would need to review the resident's hospice notes. Registered Nurse K stated that Resident 1 had been known to refuse his/her medications but usually wanted his/her Carbidopa-Levodopa as scheduled. Surveyor requested Resident 1's record. On 02/19/2024, at approximately 1:00 PM, Surveyor interviewed Caregiver H. Caregiver H stated, "[Co-Owner B] will tell [Resident 1] what meds [s/he] should take or what [s/he] should refuse. Even when [s/he] is at the hospital.	M 462		

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M 462	Continued From page 65 [S/He] will get in arguments with staff because of it." On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Manager N stated there were always concerns with resident's medications being ordered on a timely basis. Manager N stated, "The meds weren't set up on auto fill, which I do not understand why. At times, hospice would have to step in for [Resident 1] to make sure [s/he] got [his/her] meds, especially Carbidopa Levodopa and Baclofen. There were just so many med errors/concerns. [Co-Owner B] and [Licensee A] do not believe in the medications hospice orders as 'comfort meds,' like Lorazepam and Morphine. I had a situation where [Licensee A] discontinued a scheduled narcotic. I said we don't have an order to discontinue it. [Licensee A] kept giving me excuses but I reactivated it in the electronic MAR (medication administration record). I called hospice because I couldn't get [his/her] med order figured out and they had not discontinued any medications. Then I was told to hold [his/her] narcotics unless I called [Licensee A] or [Co-Owner B]. How can they do this when the medications are scheduled." On 03/02/2024, at approximately 10:35 AM, Surveyor interviewed previous Caregiver O. "Caregiver O stated, "[Co-Owner B] refused to give [Resident 1] [his/her] Baclofen. You would go to administer a medication because it is on the MAR as a scheduled medication and then [Co-Owner B] would tell you not to administer it. Then [Co-Owner B] and [Licensee A] would get into a disagreement about it. [Co-Owner B] was very disrespectful of [Licensee A] and staff. [Co-Owner B] thinks [s/he] can just change how a medication is administered even if [s/he] doesn't	M 462		

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have a physician order."

On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Caregiver W stated, "[Resident 1] would refuse [his/her] medications, but the medication should be available when [s/he] didn't refuse. [His/her] medications weren't ordered on time, then [Resident 1] would want a medication and [Manager/Caregiver F] would tell me to just take some of the old meds and give to [him/her]. That ain't right!" Caregiver W stated, [Co-Owner B] didn't want [Resident 1] to take certain medication; stating [s/he] doesn't need that medication. [S/He] didn't want [him/her] to have Morphine; it will kill [him/her] off!"

On 03/17/2024, Surveyor reviewed Resident 1's record.

Resident 1 admitted to the home, 11/14/2023, with diagnoses including Parkinson's disease with dyskinesia, dystonia, muscle weakness, muscle spasm, and depression. Resident 1 was on hospice.

Resident 1's hospice notes documented: "12/14/2023 - PT (patient) concerned about medications being given to [him/her] as [Licensee A] and [Co-Owner B] have been telling PT [s/he] does not need medication intervention. PT reports pain and would like [his/her] muscle relaxer to still be given ... education provided to [Licensee A] and [Co-Owner B] and rest of facility caregivers on medication management."

Resident 1's December 2023 Medication Administration Record (MAR) documented: "Baclofen - Take 1 tablet by mouth 4 times a day. Scheduled at 8:00 AM, 12:00 PM, 4:00 PM, 8:00

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PM. Start Date: 11/29/2023. End Date: 12/14/2023."
12/01/2023 8:48 AM - No Pass Reason: Refused by Resident
12/01/2023 12:00 PM - Documented as Administered
12/01/2023 4:00 PM - No Pass Reason: Refused by Resident
12/01/2023 9:15 PM - No Pass Reason: Waiting for Pharmacy
12/02/2023 8:13 AM - No Pass Reason: Other
12/02/2023 12:00 PM - Documented as Administered
12/02/2023 6:18 PM - No Pass Reason: Refused by Resident
12/02/2023 8:16 PM - No Pass Reason: None in Stock/New dosing starts 12/03/2023

"Carbidopa-Levodopa 25-100 MG - Take 2 tablets by mouth every 4 hours (Parkinson's). Scheduled: 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, 8:00 PM. Start Date: 11/15/2023."
12/28/2023 12:54 AM - No Pass Reason: Other - Pharmacy did not send over all medication
12/28/2023 4:20 AM - No Pass Reason: Other - Awaiting on pharmacy
12/28/2023 8:12 AM - No Pass Reason: Refused by Resident - Meds are not here
12/28/2023 11:53 AM - No Pass Reason: Refused by Resident - Meds are not here

The MAR documented that resident refused medications when they were not available.

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Licensee A and Administration C discussed the need for additional training for staff on how to

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properly document med administration. AED F nodded in agreement that residents should always have their medications available. AED F stated s/he will be auditing the medications to ensure medications are received timely.

Example 2: Resident 4

On 02/13/2024, at approximately 1:00 PM, Surveyor interviewed hospice Registered Nurse K. Surveyor asked if there were concerns with medication availability for Resident 4. Registered Nurse K stated the Surveyor would need to review the resident's hospice notes. Surveyor requested Resident 4's record.

On 02/19/2024, at approximately 1:00 PM, Surveyor interviewed Caregiver H. Caregiver H stated Co-Owner B would determine when staff could administer a resident's PRN medication. Caregiver H stated, "If you administer it prior to contacting [him/her], you could be fired."

On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Caregiver I stated Co-Owner B did not believe in Morphine. Caregiver I stated, "[Co-Owner B] had a love/hate relationship with Hospice."

On 02/25/2024, at approximately 9:45 AM, Surveyor interviewed previous Caregiver J. Caregiver J stated, "[Co-Owner B] would direct staff on what meds could be administered, even if it went against the physician orders."

On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Manager N stated, "Meds are not ordered timely. There are so many medication errors. The owners are not big believers in medications like

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morphine."

On 03/10/2024, Surveyor reviewed Resident 4's record.

Resident 4 moved into the home, 10/04/2021, with diagnoses including down's syndrome, achalasia of cardia (swallowing disorder), joint disorder, and cardiac bi-ventricular pacemaker placement.

Resident 4 was placed on hospice 07/28/2023.

Resident 4's "Hospice Notes" documented: "Visit Note Report," dated 08/21/2023, documented: "Brought PT (patient) to [his/her] room for bed and PT started to complain of chest pain, grabbing chest with both hands, oxygen started at 5L (liter) via NC (nasal cannula). Lorazepam 1 MG (milligram) and Tylenol administered. No Morphine available at facility ..."

Resident 4's July MAR documented: "Morphine Sulf ** Prefilled Syringes ** 100 MG (milligram) / 5 ML (milliliter) (20 MG/ML) Take 0.5 ML (10 MG) by mouth every hour as needed (PRN) (pain) (sob [shortness of breath]). Start Date: 10/28/2022."
The MAR did not document any administrations.

Resident 4's August 2023 MAR documented: "Morphine Sulf ** Prefilled Syringes ** 100 MG / 5 ML (20 MG/ML) Take 0.5 ML (10 MG) by mouth every hour as needed (pain) (sob). Start Date: 10/28/2022. End Date: 08/24/2023."
The MAR documented administration on 08/23/2023 by [Licensee A].
"Morphine Sulf ** Prefilled Syringes ** 100 MG / 5 ML (20 MG/ML) Take 0.25 - 1 ML (5-20 MG) by

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mouth every hour as needed (pain/sob). Start Date: 08/22/2023. End Date: 09/01/2023."
The MAR documented administration on 08/22/2023, 08/23/2023, and 08/30/2023.
Note: The MAR documented that both Morphine's were administered on 08/22/2023, but in the notes section, it documented the dosage was administered only once.

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and AED F. Licensee A and Administration C discussed the need for additional training for staff on how to properly document med administration. AED F stated s/he will be auditing the medications to ensure medications are received timely. Surveyor did not receive a response regarding the administration of morphine.

Example 3: Resident 6

On 03/10/2024, Surveyor reviewed Resident 6's record.

Resident 6's November 2023 MAR documented: "Benzoyl Peroxide - Apply to skin daily as directed at bedtime. Start Date: 07/27/2023."
MAR documented as not administered 11/03 to 11/06 due to medication not available.

Resident 6's October 2023 MAR documented: "Diphenhydramine 50 MG - Take 1 capsule by mouth at bedtime. Start Date: 10/18/2023."
MAR documented as not administered 10/05 to 10/15 due to medication not available.
10/05 - No Pass Reason: Not Here
10/06 - No Pass Reason: Not In Stock
10/07 - No Pass Reason: Not In Stock
10/08 - No Pass Reason: Meds Not In

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M 462	Continued From page 71 10/09 - No Pass Reason: N/A Will Call Pharmacy 10/10 - No Pass Reason: N/A 10/11 - No Pass Reason: N/A 10/12 - No Pass Reason: N/A 10/13 - No Pass Reason: Out of Building 10/14 - No Pass Reason: Waiting on Doctors Response for Refills 10/15 - No Pass Reason: Waiting on Doc Order On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and AED F. Licensee A and Administration C discussed the need for additional training for staff on how to properly document med administration. AED F stated s/he will be auditing the medications to ensure medications are received timely.	M 462		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by: Based on record review and interview, prior to dispensing or administering medications to a	M 464		

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resident, the facility did not obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered for 1 of 1 resident (Resident 2).

Findings include:

On 10/04/2023, the Department received a concern alleging medication orders were not being followed.

On 02/02/2024, the Department received a concern alleging a resident's oxygen levels were adjusted without a physician order.

On 02/13/24, at approximately 12:00 PM, Surveyor interviewed Co-Owner B. Surveyor asked if Co-Owner B adjusted Resident 2's oxygen levels without a physician order. Co-Owner B stated, "If I walked into [his/her] room and [s/he] appeared to be struggling with breath, yes, I adjusted [his/her] oxygen levels up to 5L (liter)." Surveyor asked again if [s/he] had a physician order for this and/or guidance on when to raise Resident 2's oxygen levels based on his/her saturation levels. Surveyor did not receive a response.

On 02/16/2024, Surveyor reviewed Resident 2's record.

Resident 2 moved into the home, 12/21/2023, on hospice, with primary diagnosis Cri-du-chat syndrome (genetic disorder).

Resident 2's "Pre-Admission Assessment," dated 12/20/2023, documented:

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M 464	Continued From page 73 "Respiratory Assessment: Normal - Needs oxygen. 88 (saturation reading) with no oxygen." Resident 2's "Initial Assessment," dated 12/26/2023, did not document that s/he was on oxygen. Resident 2's hospice "Visit Note Report," documented: -12/21/2023 Oxygen Saturation Level - 92%. On Oxygen 2L -12/22/2023 Oxygen Saturation Level - 100%. On Oxygen 2L -12/23/2023 Oxygen Saturation Level - 95%. On Oxygen 1L -12/24/2023 Oxygen Saturation Level - 95%. On Oxygen 2L -12/25/2023 Oxygen Saturation Level - 95%. On Oxygen 2L -12/26/2023 Oxygen Saturation Level - 93%. On Oxygen 2L -12/27/2023 Oxygen Saturation Level - 97%. On Oxygen 2L -12/28/2023 Oxygen Saturation Level - 95%. On Oxygen 2L -12/28/2023 Oxygen Saturation Level - 99%. On Oxygen 2L -12/29/2023 Oxygen Saturation Level - 95%. On Oxygen 2L -12/30/2023 Oxygen Saturation Level - 93%. On Oxygen 2L -12/31/2023 Oxygen dependent at 3L -01/04/2024 Oxygen at 4L -01/07/2024 Oxygen Saturation Level - 93%. On Oxygen 2.5L -01/08/2024 12:12 PM Oxygen Saturation Level - 85%. On Oxygen 3L -01/08/2024 12:13 PM Oxygen Saturation Level - 89%. On Oxygen 4L -01/08/2024 12:12 PM Oxygen Saturation Level -	M 464		

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92%. On Oxygen 4L
-01/10/2024 11:20 AM Oxygen on at 4L nasal cannula
-01/10/2024 7:29 PM Resident Expired during visit

On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Caregiver I stated, "I have witnessed [Resident 2] trying to get the oxygen off [him/herself]. I would look at [his/her] oxygen level and it would be set at level 5. I turned it down. I explained the concern to [Lead Caregiver P] and we were mad because [Co-Owner B] insisted on turning [Resident 2's] oxygen levels up too high. With [Resident 2's] oxygen levels turned up too high, we could have exacerbated the situation; it could cause [his/her] death to occur sooner. We would talk with [Co-Owner B] about this and [s/he] would just say 'I know what I am doing' and walk away." Caregiver I stated, "I never saw a physician order or guidelines on when we should increase/decrease Resident 2's oxygen levels based on [his/her] saturation levels."

On 02/24/2024, at approximately 5:15 PM, Surveyor interviewed Caregiver EE. Caregiver EE stated, "The first time I met [Resident 2] was with [Co-Owner B]. We walked into [his/her] room and [Co-Owner B] walked over and increased [Resident 2's] oxygen. I never saw a physician order for what [his/her] oxygen levels were to be set at." Surveyor asked if Resident 2's oxygen levels were checked prior to Co-Owner B adjusting [his/her] oxygen. Caregiver EE stated Resident 2's oxygen levels were not checked.

On 02/25/2024, at approximately 9:45 AM, Surveyor interviewed previous Caregiver J. Caregiver J stated there were concerns regarding

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Co-Owner B adjusting Resident 2's oxygen levels without a physician order.

On 02/26/2024, at approximately 11:30 AM, Surveyor interviewed Resident 2's Power of Attorney (POA) Q. Surveyor asked if Resident 2 required his/her oxygen levels to set at 5L. POA Q, "[Resident 2] was a little thing, that would have been like a wind tunnel through [him/her]."

"Giving yourself oxygen without talking to a doctor first may do more harm than good. You may end up taking too much or too little oxygen. Deciding to use an oxygen concentrator without a prescription can lead to serious health problems, such as oxygen toxicity caused by receiving too much oxygen. ... Even though oxygen makes up about 21 percent of the air around us, breathing high concentrations of oxygen may damage your lungs. On the other hand, not getting enough oxygen into the blood, a condition called hypoxia, could damage the heart, brain, and other organs." (Source: FDA (US Food & Drug Administration) website, Pulse Oximeters and Oxygen Concentrators: What to Know About At-Home Oxygen Therapy, 02/19/2021, https://www.fda.gov/consumers/consumer-updates/pulse-oximeters-and-oxygen-concentrators-what-know-about-home-oxygen-therapy#:~:text=You%20may%20end%20up%20taking,by%20receiving%20too%20much%20oxygen (retrieval date: 04/10/2024).)

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director F. Surveyor asked if Co-Owner B or any staff members had been given physician orders to determine when Resident 2's oxygen levels were to be adjusted.

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M 464	Continued From page 76 Co-Owner B stated hospice discussed it verbally with him/her. Surveyor asked where these guidelines were documented. Surveyor did not receive a response.	M 464		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure accurate records were kept of all prescription medications administered for 2 of 3 records reviewed. Resident 4's and 6's Medication Administration Records (MAR) were not correctly documented during medication administration. Resident MARs did not reflect accurate medication administration times. Findings include: On 10/04/2023, the Department received a concern alleging medication errors are overlooked and not reported. On 02/02/2024, the Department received a	M 466		

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concern alleging medication administration was not being documented correctly.

On 03/19/2024, Surveyor reviewed Resident 4's and Resident 6's record.

Example 1: Resident 4

Resident 4's August 2023 MAR contained blanks where initials should have been documented to show that medication administration had been completed on the following dates: for the following medications:
08/05, 08/18 and 08/28 8:00 AM - Fluoxetine, Ferrous Sulfate, Vitamin B-12, and Famotidine.
08/01 to 08/08, 08/18, and 08/28 8:00 AM - Polyethylene
08/23 8:00 PM - Nystop and No Sting Barrier Film
08/25 8:00 AM - Nystop and No Sting Barrier Film

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Licensee A and Administration C discussed the need for additional training for staff on how to properly document med administration. AED F stated s/he will be auditing the medications to ensure medications are received timely and updated in the electronic MAR timely.

Example 2: Resident 6

Resident 6's October and November 2023 MAR documented:
"Bisacodyl 10 MG (milligram) - unwrap insert 1 suppository rectally at 3PM every other day. Start Date: 07/02/2023. End Date: 11/04/2023."
"Bisacodyl 10 MG - unwrap insert 1 suppository rectally at 3PM every other day. If no result

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administer another suppository the next day 1 hour prior to lunch (constipation). Start Date: 11/04/2023. End Date: 12/04/2023."

On 02/14/2024, at approximately 11:20 AM, Surveyor interviewed Caregiver F. Caregiver F stated, "[Resident 6's] [mother/father] expected things to be done [his/her] way, especially regarding medications, [s/he] did not care that staff had to follow physician orders. [Father/Mom] would want them given more often than directed."

On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Caregiver I stated, "[Resident 6's] [Power of Attorney (POA) Z] would administer the suppository when [s/he] wasn't supposed to. We would try to explain that we needed to follow physician orders. [S/he] didn't care. Then we would end up documenting that we administered a medication when we didn't." Caregiver I stated, "On numerous occasions the suppository that was marked off as not given in ECP (electronic computer system), I would notice the next day or shift I worked, that the suppository was changed to 'passed.' I would question this on a few occasions, and I was told by [Licensee A] 'It's not a problem.'"

On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Caregiver M stated, "[POA Z] used to do [Resident 6's] suppository and then I was told I had to sign in the MAR that I gave it, but I am not going to sign off on it because I didn't administer it and/or see that it had been administered. [POA Z] did not follow the physician order."

On 03/01/2024, at approximately 2:15 PM,

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Surveyor interviewed previous Manager N. Manager N stated, "[POA Z] would say [Resident 6] needed one. [POA Z] would try to give the suppository's without following the physician order (PO). I had to have a discussion with [POA Z] that we have to follow the PO; we can't have you administering meds in our building. So, [s/he] would wait until I was out of the building then come in to give [Resident 6] a suppository, even if [s/he] already had one. [S/he] would give [him/her] 3 to 4 a day. I also had discussions with [Licensee A] about these concerns; explaining we do not document med pass that we do not observe and that we have to follow the physician orders."

On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Caregiver W stated POA Z was obsessed with Resident 6's suppositories.

On 03/08/2024, at approximately 10:45 AM, Surveyor interviewed previous Caregiver V. Caregiver V stated, "[POA Z] came in and started passing meds (suppository) and you be like that is not how we do it. It would turn into a battle. Then [Co-Owner B] and [Licensee A] would get involved and they said let [POA Z] do whatever [s/he] wants. I said I would not document this kind of med administration, so [Licensee A] would go in and amend the MARs to look like I did administer the medication."

On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver JJ and previous Caregiver KK. Caregiver JJ stated, "There was also the problem that the suppositories were not given but documented as administered. We would count the suppositories before we would leave our shift and when we

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worked again, the same number of suppositories would still be in the med cart. They would chart the suppository was given but they weren't. We would tell [Licensee A] and [s/he] would say 'oh sometimes [Resident 6] refuses' but it was marked as given even though it wasn't."

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and AED F. Surveyor asked for explanation on why staff reported that Resident 6's suppositories were not administered as ordered and that the MARs did not reflect an accurate reflection of these administrations. Licensee A asked, "I can't mark down that a medication was given at 8:00 AM if it was ordered at 3:00 PM?" Licensee A stated, "We need the MAR to show that medications are being given." AED F stated, "We have to follow the physician orders." Licensee A, Co-Owner B, Administration C, and AED F discussed what practices should be followed when family members are requesting a medication that the provider does not have a physician order for and how to document on the MAR if a family member administers a medication.

Example 3: Resident MARs

On 02/14/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver CC. Caregiver CC stated, "Each staff member has their own ID and password for the electronic computer program (ECP). I have been told you can go in and change the time that you passed a medication."

On 02/14/2024, at approximately 1:20 PM, Surveyor interviewed Licensee A. Surveyor

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discussed the concern that management was changing medication administration times. Licensee A stated, "I have amended med errors if staff do not do it correctly." Surveyor asked if Licensee A's initials would then appear on the MARs to show that s/he had amended the document. Licensee A stated, "Staff can document under another staff members ID if that staff member forgets to log out. I have done it." Surveyor asked if s/he knew that another person was logged in, since s/he wasn't required to log in. Licensee A did not respond.

On 02/24/2024, at approximately 5:15 PM, Surveyor interviewed Caregiver EE. Caregiver EE stated, "[Licensee A] changes documentation. [S/he] changed my medication pass one time. [S/he] corrected a med error I made. It is known around the building [Licensee A] and [Caregiver F] have gone in and fixed the times of medication administration."

On 02/25/2024, at approximately 9:45 AM, Surveyor interviewed previous Caregiver J. Caregiver J stated, "[Licensee A] has changed my med pass times at least 3 times. If you think you made an error or forgot to document, you would tell [Licensee A] and [s/he] would say, 'don't worry, I will fix it.'"

On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Caregiver M stated management can go and fix med administration times. Caregiver M stated, "If we made an error, management would say they would fix it later."

On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Manager N stated, "[Licensee A] and [Manager F]

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M 466	Continued From page 82 would always go in and fix the times during MAR administration if a medication was passed late. They don't want it to look like a med was passed late." On 03/08/2024, at approximately 10:45 AM, Surveyor interviewed previous Caregiver V. Caregiver V stated, "[Licensee A] will go in and amend the MARs if [s/he] thinks you are doing it wrong." On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver S. Caregiver S stated management would mark that you passed a medication even if you did not. Caregiver S stated, "If medications were not passed, the medications were not properly destroyed, a med error report would not be filled out. The medications would be thrown in the garbage and not given a second thought." On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and AED F. Surveyor did not receive a response regarding these concerns.	M 466		
M 470	88.07(4)(a) NUTRITION A licensee shall provide each resident with a quantity and variety of foods sufficient to meet the resident's nutritional needs and preferences and to maintain the resident's health. This Rule is not met as evidenced by: Based on observation, record review, and	M 470		

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interview, the provider did not ensure each resident received a variety of food that met their individual preferences and maintained resident health. There was a limited amount of food readily available in the refrigerator, freezer, and cabinets.

Findings include:

On 02/02/2024, the Department received a concern alleging there is a limited amount of food available to residents.

The licensee can provide cares for up to 4 residents in the client groups: irreversible dementia/Alzheimer's, advanced aged, physically disabled, emotionally disturbed/mental illness, and developmentally disabled.

On 02/13/2024, at approximately 3:50 PM, Surveyor interviewed Lead Caregiver P. Lead Caregiver P stated, "There could be concerns regarding available food, because some staff do not know how to cook, so they will make what they know how."

On 02/14/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver CC. Caregiver CC stated, "Food does come up missing. I wonder if staff is eating it or taking it home. It could be because staff ruined the meal, so they have to make something else. Menus are not really made in advance, we are told day-to-day what to make, or we are looking at what food is available and determine what we are going to make. We have family members who bring in food or food specific to them (Resident 5). There really isn't much variety."

On 02/14/2024, at approximately 11:30 AM,

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Surveyor toured the kitchen with Manager E. Surveyor stated that the food supply appeared to be limited. Manager E stated, "I do not understand where the food goes. I purchase food and then it disappears. I need to figure out if staff are eating the food or taking it home."

On 02/14/2024, at approximately 3:00 PM, Surveyor interviewed Co-Owner B. Co-Owner B stated the food supply was low due to it being the end of the week. Co-Owner B stated s/he would be reviewing the menus and determining what food needed to be purchased for the upcoming week.

On 02/19/2024, at approximately 1:00 PM, Surveyor interviewed Caregiver H. Caregiver H stated, "Food is disappearing, but I can find enough food to make a meal."

On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Manager N stated, "I strongly believe [Manager F] was stealing money from the company. There was no food in the house when I started, None! [Manager F] informed me s/he would go to the food pantry to get food for the residents. I questioned [him/her] about the food budget, [s/he] said [s/he] don't get enough money. Then I was put in charge of the groceries. I was given $600, the same as [him/her]. [Lead Caregiver P] and I sat down and figured it out, we were easily able to fill the house with groceries. [Licensee A and Co-Owner B] did not have an audit process in place, so they didn't monitor [Manager F]."

On 03/02/2024, at approximately 9:20 PM, Surveyor interviewed Caregiver L. Caregiver L stated, "There is always an issue with food, scarce on food. I don't understand it. I throw

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things together to make a meal for everybody. I have not heard that it came from food pantry, but the food is always the knock off cheap stuff and that would make sense."

On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Caregiver W stated there is never enough food. Caregiver W stated, "We need to get a variety of food. There should be enough for seconds. We would fish for food to make a meal. Caregivers have brought in food. [Caregiver F] has brought in food from the food pantry."

On 03/06/2024, at approximately 2:50 PM, Surveyor interviewed Caregiver W. Caregiver W stated, "It is funny, since you have been showing up, [Co-Owner B] immediately shows up with food. The residents appreciate that you were able to help with that."

On 03/08/2024, at approximately 10:45 AM, Surveyor interviewed previous Caregiver V. Caregiver V stated there were concerns with how much food was in the house. Caregiver V stated, "I have gone and purchased food with my own money, so that I could cook a nice homecooked meal for the residents."

On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver S. Caregiver S stated, "At times food was non-existent. Employees have been known to get food for the residents. [Manager F] would bring food in from the food pantry."

On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver JJ and Caregiver KK. Caregiver JJ stated, "Staff would cook what they wanted or what they knew how to;

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M 470	Continued From page 86 they did not follow the menu that was posted. This would cause problems for other shifts, who followed the menu, because the food wasn't available." Caregiver JJ stated that staff would eat the food which caused behaviors in residents when they requested seconds, and the food was gone. Caregiver JJ and Caregiver KK explained that the food was always being stolen from the home. Staff would use personal funds to purchase food and Assistant Executive Director had been known to bring food in from the food pantry. Caregiver JJ and Caregiver KK stated that residents had been known to buy bread, jelly, and peanut butter, so they could make sandwiches if they were still hungry. On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F (Manager F). Co-Owner B stated s/he took offense to this concern as the home had plenty of food in it. Licensee A stated there had been concerns with staff not following the menu which caused concerns. Surveyor did not receive a response regarding if food had been brought in from a food pantry.	M 470		
M 474	88.07(4)(c) FOOD PREPARED AND STORED SANITARY WAY Food shall be prepared and stored in a sanitary manner. This Rule is not met as evidenced by: Based on observation and interview, the provider	M 474		

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did not store food under sanitary conditions. Surveyor found food items in the refrigerator and pantry that were not properly sealed to avoid contamination and food items in the freezer that were not properly sealed to avoid freezer burn. The provider did not implement a system to identify when opened food was to be discarded for the prevention of food borne illnesses.

Findings include:

The licensee can provide cares for up to 4 residents in the client groups: irreversible dementia/Alzheimer's, advanced aged, physically disabled, emotionally disturbed/mental illness, and developmentally disabled.

On 01/31/2024, at approximately 11:10 AM, Surveyor toured the kitchen and observed the following:

Refrigerator:
-A clear plastic bag of opened of what appeared to be bacon strips that was not dated.
-A clear plastic bag of what appeared to be sausage links that was not dated.

Freezer:
-An opened 32-ounce package of bean & cheese burritos that was not sealed.
-An opened 12 pack of crispy battered fish portions that was not sealed.
-An open bag waffles that was not sealed.

Pantry:
-An opened 5-pound bag of flour that was not sealed.
-An opened 10 ounce bag of plain potato chips.

On 04/11/2024, at approximately 12:30 PM,

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M 474	Continued From page 88 Surveyor toured the kitchen and observed the following: Refrigerator: -(2) 12 ounce packages iceberg salad mix, with a handwritten date of 04/01/2024, that showed signs of spoilage as the green leaves had a brown slimy appearance. Freezer: -An opened 32-ounce package of bean & cheese burritos that was not sealed. -An opened 12 pack of crispy battered fish portions that was not sealed. -An open bag waffles that was not sealed. Pantry: -An opened 5-pound bag of flour that was not sealed. -A bag of red potatoes that showed signs of spoilage by being soft to the touch. -14 ounce opened box of rice that was not sealed. "Time/temperature control for safety (TCS) guidelines indicate food prepared in a food establishment and held longer than a 24 hour period shall be marked to indicate the date or day by which the food is to be consumed on the premises, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Refrigerated, RTE (ready-to-eat)/TCS food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed or discarded." (US Food and Drug Administration	M 474		

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M 474	Continued From page 89 (FDA) Food Code, 2022, Section 3-501.17) "Ready-to-eat TCS food (foods that need time and temperature control for safety) can be stored for only seven days if it is held at 41 degrees Fahrenheit or lower. The count begins on the day the food was prepared or a commercial container was open. TCS foods includes milk and dairy products, eggs, meat (beef, pork, and lamb), poultry, fish, shellfish and crustaceans, baked potatoes, tofu or other soy protein, sprouts and sprout seeds, sliced melons, cut tomatoes, cut leafy greens, untreated garlic-and-oil mixtures, and cooked rice, beans, and vegetables." (ServSafe Coursebook, 7th edition, 2017, p. 1-7, p. 1-8, and p. 7-3) On 01/31/2024, at approximately 11:20 AM, Surveyor interviewed Co-Owner B. Co-Owner B stated s/he would remind staff that food is to be stored properly and dated when it is opened. On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Licensee A and Co-Owner B stated the concern would be addressed.	M 474		
M 478	88.07(4)(e) SPECIAL DIETS Meals prepared by the licensee shall take into account special physical and religious dietary needs of the residents. A special diet shall be served to a resident if prescribed by the resident's physician.	M 478		

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M 478	Continued From page 90 This Rule is not met as evidenced by: Based on record review, observation, and interview, the provider did not ensure 1 of 1 resident was served a diet that reflected his/her allergies. Resident 5, who was allergic to lime and lemon, was served food items that contained those ingredients. Findings include: On 01/31/2024, at approximately 11:30 AM, Surveyor observed a staff member give Resident 5 a fruit cup. Resident 5's Power of Attorney (POA) Y walked up to the staff member and asked if the fruit cup contained lime/lemon juice. The staff member was unable to answer POA Y. POA Y proceeded to look the ingredients up on Google where it was determined the fruit juice contained lime/lemon juice. POA Y took the fruit cup from Resident 5. On 01/31/2024, Surveyor reviewed Resident 5's record. Resident 5 admitted to the home, 11/06/2020, with diagnoses including vascular dementia, hyponatremia (when the level of sodium in your blood is lower than normal) and hyperlipidemia (high cholesterol). Resident 5's "Client Fact Sheet" documented: "Allergies: Citrus fruit, eggs, environmental, odors, fumes, tape, trees, pollens, Lemon, Lime." Resident 5's "6 Month Assessment," dated 05/03/2023, documented: "Eating: Independent - requires no assistance with eating meals. [Resident 5] prefers soft food.	M 478		

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Staff to chop up all foods."
"Eating: Food Consumption - Assistance required in monitoring eating meals. Staff to document consumption monitoring per meal and assist as needed."
"Special Dietary Needs - Fluid Intake: [Resident 5] has been hospitalized for dehydration 02/12/2022 because resident does not like to go to the bathroom so [s/he] refuses to drink. Staff to offer drink per schedule. Staff will monitor fluid intake during awake hours."
"Meal Preparation - Assist: Staff prepare all meals"

Resident 5's "Individual Service Plan (ISP)," dated 12/07/2023, documented:
"Eating: Monitor percentage consumed."
"Eating: Independent - requires no assistance with eating meals. [Resident 5] prefers soft food. Staff to chop up all foods."
"Special Dietary Needs - Fluid Intake: Staff to offer minimum of 8oz juice or water at scheduled times or as needed."
"Meal Preparation - Full Assist: Caregiver to provide full assistance with meal preparation."
The ISP did not identify any of Resident 5's food allergies.

Resident 5's "Observations," dated 01/01/2023 to 01/31/2024 did not document food consumption.

On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Caregiver I stated s/he was aware of Resident 5's food allergies due to his/her Power of Attorney (POA) Y informing him/her. Resident 5 had a sensitivity to lime, and s/he observed staff use 'Mrs. Dash' with lemon on his/her food. Caregiver I stated, "Some staff don't pay attention and some staff probably were never told."

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M 478	Continued From page 92 On 02/25/2024, at approximately 9:45 AM, Surveyor interviewed previous Caregiver J. Caregiver J stated, "[Resident 5] would tell you that [s/he] can't have citrus." Caregiver J stated staff often times did not know a resident's diet restrictions until after the fact. On 02/25/2024, at approximately 10:35 AM, Surveyor interviewed POA Y. POA Y stated, "When I visit, I have to always check to make sure they aren't feeding [him/her] lemon/lime; [s/he] is allergic. They don't check. The staff is constantly changing. Who tells them? [S/he] also had a bad reaction with cabbage. [S/he] will show more behaviors. I am sure that is not documented anywhere." On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Caregiver M stated Resident 5 had food restrictions, soft food only. Caregiver M stated, "We didn't know what [s/he] could or could not eat until [his/her] [son/daughter] would be visiting and be like 'you can't eat that!'" On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Manager N stated, "Diet concerns were a juggle; we didn't have a doctor's order to specify a diet. I would request physician orders, so that I could care plan the resident's food. I care planned [Resident 5's] food. It was to be soft foods, chopped. They didn't list her allergies in [his/her chart], so I had to add that." On 03/02/2024, at approximately 10:35 AM, Surveyor interviewed previous Caregiver O. Caregiver O stated management did not tell staff about Resident 5's diet restrictions, POA Y did.	M 478		

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M 478	Continued From page 93 On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver S. Caregiver S stated, "We are not given anything specific about diets. You would hope other staff told you or maybe a resident would say something. [Resident 6's] [mother/father] made us a book." On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Licensee A and Co-Owner B stated staff were aware that Resident 5 was allergic to lime/lemon.	M 478		
M 482	88.09(1)(a) RESIDENT RECORDS The licensee shall maintain a record for each resident. Resident records shall be maintained in a secure location within the home to prevent unauthorized access. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 1 resident's (Resident 1) record contained all required information and was maintained in a secure location within the home. The provider did not ensure resident records contained complete information recorded by staff. Findings include: Example 1: Resident 1	M 482		

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M 482	Continued From page 94 On 10/04/2023, the Department received a concern alleging resident falls were not being documented. On 01/31/2024, at approximately 12:45 PM, Surveyor reviewed Resident 1's record with Manager C and Manager D. Surveyor stated the most recent ISP for Resident 1 that was available, in his/her binder, was dated 03/2023. Resident 1 moved into the home 02/14/2023. Manager C reviewed the electronic software and stated there were no other ISPs available. On 02/01/2024, Surveyor requested Resident 1's current ISP from Administrator A and Administration Staff (AS) F. Administrator A forwarded ISPs dated 06/01/2023 and 12/05/2023. On 02/02/2023 at 7:33 AM, Surveyor emailed AS F and asked why the ISPs were not available to staff on 01/31/2024. On 02/05/2024 at 10:25 AM, Surveyor emailed Administrator A and F and asked why the ISPs were not available to staff on 01/31/2024. On 02/05/2024 at 11:23 AM, Administrator A emailed Surveyor stating s/he was informed that the ISPs were pulled from the binder. On 02/05/2024 at 12:28 PM, Administrator A emailed Surveyor stating, "Caregiver E said that s/he did the ISP, but someone must have deleted them, so they had to be re-created based on their conditions." Example 2: Resident Records On 02/14/2024, at approximately 1:20 PM,	M 482		

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Surveyor interviewed Licensee A. Surveyor discussed concerns that resident records were being amended so that concerns/incidents that could be flagged as concerning were removed from the record. Licensee A stated, "If I do not feel staff filled documentation out correctly, I will change the document. If the progress note is written incorrectly, an incident report filled out incorrectly, a medication pass."

On 02/19/2024, at approximately 1:00 PM, Surveyor interviewed Caregiver H. Caregiver H stated, "Everybody knows [Manager/Caregiver F] changes the documents for [Co-Owner B] and [Licensee A]." Caregiver H explained that [Co-Owner B] will not take responsibility for anything that could possibly need to be recorded; [s/he] will turn it into a 3-way call, s/he would usually include [Manager/Caregiver F], that way [Manager/Caregiver F] can take care of the documentation."

On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Caregiver I stated, "[Licensee A] is notorious for deleting notes/documents. [Co-Owner B] is notorious for 3-way calls. Why don't we have internal email updates on residents; like during shift changes so we are all updated on cares. [Manager/Caregiver F] said it had to do with legality reasons; if there are no paper trails then they cannot be held accountable."

On 02/25/2024, at approximately 9:45 AM, Surveyor interviewed previous Caregiver I. Caregiver I stated, "[Licensee A] would tell people not to use the word 'fall,' state doesn't like it when residents fall."

On 03/01/2024, at approximately 2:15 PM,

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Surveyor interviewed previous Manager N. Manager N stated, "Incident reports were not filed properly. [Manager F] falsified documentation. As a manager [s/he] was responsible to make sure the houses ran smoothly but [his/her] response to everything was 'I haven't gotten to that.'"

On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Surveyor asked how often Caregiver W charted progress notes for residents, for example Resident 3. Caregiver W stated, "[Resident 3] is a huge fall risk, like [s/he] falls daily, so I would document when s/he had a fall." Surveyor reviewed Resident 3's observation notes for January 2024 and informed Caregiver W that there were two entries by him/her, and they were not regarding falls. Caregiver W stated, "Where do the incident reports go, [s/he] falls every other day. I am constantly filling out incident reports. [Licensee A] would tell me, 'I can go in and finish out the rest.'"

On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver JJ. Caregiver JJ stated, "[Licensee A] would be in a rush and be telling me that a resident's care manager or family member was coming in and they want to look at the individual service plans (ISP). [Licensee A] wasn't going to be at the meeting, so [s/he] would say just print it off. Then my name would print on it, so it would look like I am the one that created the ISP. I was not a manager, that was not my role."

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F (Manager/Caregiver F). Surveyor discussed the

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M 482	Continued From page 97 concerns of what documentation should be included in a resident record to assist with monitoring. AED F stated s/he had been documenting more in the observation notes. Surveyor did not receive a response as to staff's comments about their notations being deleted.	M 482		
M 548	88.10(3)(a) Fair Treatment Fair treatment. To be treated with courtesy, respect and full recognition of the resident's dignity and individuality. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were treated with courtesy, respect and full recognition of the resident's dignity and individuality. Co-Owner B continued to go into Resident 1's room alone even though Resident 1 repeatedly stated s/he was uncomfortable when Co-Owner B was in his/her room. Resident 2, who was on hospice and actively passing, was not provided dignity when his/her room was shown during tours for potential new residents by Co-Owner B. Resident 4, who was on hospice, was not provided dignity when his/her personal belongings were removed from his/her room, so that pictures could be taken for potential new residents. Findings include:	M 548		

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On 02/02/2024, the Department received a concern alleging resident's private information was discussed openly with non-resident representatives.

The provider is licensed to care for up to 4 residents in the client groups of: irreversible dementia/Alzheimer's disease, physically disabled, emotionally disturbed/mental illness, developmentally disabled and advanced aged.

On 02/05/2024, Surveyor reviewed Resident 2's record.

Resident 2 moved into the home, 12/21/2023, on hospice, with primary diagnosis Cri-du-chat syndrome (genetic disorder). Resident 2 passed away on 01/10/2024.

Resident 2's "Pre-Admission Assessment," dated 12/20/2023, documented:
"Comfort Care - Hospice"
"Nonverbal"'

On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Caregiver I stated Co-Owner B was giving a tour of the facility on 01/03/2024 or 01/04/2024 around 5:30 PM. Caregiver I stated s/he observed Co-Owner B showed Resident 2's room and asked the family of the potential resident not to look at the resident who was lying in his/her bed.

On 02/26/2024, at approximately 2:20 PM, Surveyor interviewed Lead Caregiver P. Lead Caregiver P stated s/he had observed Co-Owner B show Resident 2's bedroom to potential residents.

On 03/04/2024, at approximately 5:30 PM,

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Surveyor interviewed Caregiver W. Caregiver W stated s/he observed Co-Owner B show Resident 2's room to a potential resident. Caregiver W stated, "Who does that!"

On 03/08/2024, at approximately 3:25 PM, Surveyor interviewed Resident 2's Power of Attorney (POA) Q. Surveyor summarized his/her interviews with staff. POA Q stated, "[S/He] showed [his/her] room? With [him/her] in it! What is wrong with [him/her]!"

On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed Caregiver S. Caregiver S stated, "I came into work and all of [Resident 4's] belongings were removed from [his/her] room. [His/Her] coloring books, pictures, games. I asked [Co-Owner B] where was [Resident 4's] stuff. [Co-Owner B] told me that [Resident 4] was going to die soon, so we need to start getting ready to rent out the room. [Co-Owner B] was taking pictures of the room."

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Surveyor asked if Resident 2's room was shown while s/he was actively passing. Co-Owner B stated, "When we show a room, we always get the families/residents permission, but if the door is open during a tour, individuals may be able to see in the room. [Resident 2] lived with [his/her] door open. That would be considered improper and inconsiderate." Surveyor asked if there were processes in place for hospice patients when potential residents were touring the place to ensure their dignity. Licensee A stated, "We have pictures of the room. Rooms are private." Surveyor asked if Resident 4's belongings were removed from his/her room to take pictures of the room. Licensee A stated, "We put them back."

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M 552	88.10(3)(c) Confidentiality Confidentiality. To have his or her records kept confidential as described in s. HSS 88.09(1)(b). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that resident and staff personal information was kept confidential. Findings include: On 02/14/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver X. Caregiver X stated Co-Owner B "gossips too much." Caregiver X explained that Co-Owner B will talk to staff, residents, family members about other staff members and residents, their medical situations usually. Caregiver X was hired on 12/24/2023. On 02/14/2024, at approximately 2:25 PM, Surveyor interviewed Manager E. Manager E stated Co-Owner B was always in violation of HIPAA guidelines, daily. Manager E stated, "[Co-Owner B] discussed resident information with POA's (power of attorney) of other residents." Manager E stated there were no protocols in the home. Manager E was hired in 12/2023. On 02/21/2024, at approximately 4:30 PM, Surveyor interviewed Resident 6's Family Member CC. Family Member CC stated, "[Co-Owner B] is a gossiper. [S/He] talks about all of the residents to the visitors, myself included. I moved [Resident 6] in on 08/24/2023. Even when I was there touring the home prior to [his/her] placement, [Co-Owner B] was telling me	M 552		

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resident diagnoses, and be careful of [Resident 7], [s/he] may touch you inappropriately."

On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Caregiver I stated, "I was taking a resident to the bathroom and [Co-Owner B] was doing a tour of the facility with a potential resident and [s/he] was naming the residents and their diagnoses to these individuals. Had the attitude of 'we can take care of you, see all these diagnoses in our homes.'" Caregiver I was employed 10/2023 to 01/2024.

On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Manager N stated Co-Owner B and Licensee A would be breaking HIPAA and s/he would have to ask them to take their phone calls outside as they were discussing resident information in front of the resident in question and other residents. Manager N stated s/he would be approached by family members and asked specific questions about a resident, who was not their "loved one." Manager N stated, "I would be told [Manager F] said 'whatever' and they wanted me to provide them additional information. I would state that [Manager F] should not have discussed that information with you." Manager N was hired from 10/2023 to 12/2023.

On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver Z. Caregiver Z stated, "[Co-Owner B], [Licensee A], and [Manager F] would violate HIPAA, because family members would ask them about other residents, they would always answer. Family should not be entitled to other resident's info just because they played games with the person."

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M 552	Continued From page 102 On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F (Manager F). Co-Owner B stated, "We have family members who speak among themselves, but can be loud about it." Licensee A stated, "Family will ask questions about other residents, and we have to remind them that they cannot share that information with them." Surveyor reminded them that the concerns were that management, including Licensee A and Co-Owner B, were violating HIPPA. Licensee A confirmed that staff and management need to be aware of their surroundings when discussing resident concerns.	M 552		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not safeguard 3 of 3 residents from environmental hazards. The provider's water temperature exceeded 115°	M 570		

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M 570	Continued From page 103 Fahrenheit (F) at resident bathroom sink faucet. Toxic chemicals were not securely stored. Findings include: The licensee can provide cares for up to 4 residents in the client groups: irreversible dementia/Alzheimer's, advanced aged, physically disabled, emotionally disturbed/mental illness, and developmentally disabled. Example 1: Water Temperature On 01/31/2024, at approximately 11:00 AM, Surveyor toured the environment. Surveyor tested the hot water temperatures at the resident's bathroom sink faucet which temped at 126.5° F. "Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding; e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." (Source: Publication DHS P-01942 - 08/2017). On 01/31/2024, at approximately 2:45 PM, Surveyor interviewed Manager C and Manager D. Manager D stated s/he would inform the maintenance staff to adjust the hot water heater. Example 2: Toxic Chemicals	M 570		

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M 570	Continued From page 104 On 01/31/2024, at approximately 11:00 AM, Surveyor toured the environment and observed the following cleaning compounds unsecured in the kitchen sink cabinet: -26 ounce bottle of bath foaming cleaner -32 fluid ounce bottle of streak-free window cleaner -Gallon jug of bleach -24 fluid ounce bottle of leather cleaner & conditioner -128 fluid ounce bottle of multipurpose cleaner - lemon scent -32 fluid ounce bottle of cleaner with bleach -13 ounce bottle of multipurpose cooktop cleaner -24 ounce spray can of oven cleaner Residents were observed to be ambulating freely throughout the home. On 01/31/2024, at approximately 2:45 PM, Surveyor interviewed Manager D and Manager E. Manager E stated s/he would inform the maintenance staff that a lock would need to be added to the kitchen sink cabinet. On 02/08/2024, Surveyor reviewed his/her interviews to determine if a resident would be at risk if they had access to cleaning compounds/chemicals: Resident 1's "Observations" documented: 11/17/2023 - Resident is really sad and depressed [s/he] told both staff members that [s/he] would rather be in the lord's hands, and [s/he] wants [his/her] [daughters/sons] to have peace and for them not to worry about [him/her]. 11/30/2023 - Had a freezing episode around 7:40 PM. 12/06/2023 - Writer spoke to care staff. Care staff stated resident had [his/her] T-shirt wrapped	M 570		

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M 570	Continued From page 105 around the side rail, over [his/her] body and around [his/her] neck as if [s/he] was trying to coke [sic: choke] [him/herself]. Care staff stated that when [s/he] tried to get resident to release the shirt [s/he] hesitated and refused momentarily. Care staff immediately went to get management. Management came down from office to assess the resident. When management questioned the resident if [s/he] tried to choke [him/herself] resident stated that "[S/he] doesn't know." Writer reached out to hospice to advise. As writer called hospice, resident then tried to throw [him/herself] on the floor. Care staff was able to stop [him/her] from falling on the floor. When writer asked resident if [s/he] tried to fall on purpose to inflict harm on [him/herself] resident stated, "Yes." Hospice advised writer to send resident to hospital. Owner wanted hospice to come out and evaluate resident prior to sending [him/her] to hospital. Writer awaiting hospice to arrive. Owner aware. 12/06/2023 9:15 PM -Resident is being transferred to [hospital] for mental health evaluation. 12/07/2023 3:15 PM -Writer spoke to [hospital]. Hospital stated resident was admitted around 1AM today.	M 570		
M 572	88.10(3)(m) Freedom from Abuse Freedom from abuse. To be free from physical, sexual or mental abuse, neglect, and financial exploitation or misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were free from misappropriation of property.	M 572		

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Resident 3 had a blister card of 10 tablets of Oxycodone (pain medication) 5 MG (milligram) with 2 tablets dispensed that were not accounted for.
Resident 4's and Resident 6's petty cash was misappropriated.

Findings include:

The licensee can provide cares for up to 4 residents in the client groups: irreversible dementia/Alzheimer's, advanced aged, physically disabled, emotionally disturbed/mental illness, and developmentally disabled.

Example 1: Resident 3

On 10/04/2023, the Department received a concern alleging medication errors are not reported.

On 01/31/2024, at approximately 11:30 AM, Surveyor interviewed Administrator B and Manager C. Administrator B stated the police had been contacted due to potential misappropriation of medications, Resident 3's Oxycodone.

On 01/31/2024, Surveyor reviewed Resident 3's record.

Resident 3 admitted to the home, 09/04/2020, with diagnoses that included: Stage 4 chronic kidney disease, chronic pain, and chronic continuous use of opioids.

Resident 3's January 2024 Medication Administration Record (MAR) documented: "Oxycodone HCL 5 MG - Take 1 tablet by mouth

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every 4 hours as needed (PRN). Start Date: 01/04/2024." Blister card contained 10 tablets. Administered on 01/04/2024 and 01/05/2024.

Resident 3's Oxycodone "Controlled Substance Count Log" documented:
01/05/2024 to 01/21/2024 6:30 AM - 8 tablets
01/21/2024 3:00 PM - 0 tablets
01/21/2024 11:00 PM - 0 tablets
01/22/2024 8:45 AM - 0 tablets
01/22/2024 3:15 PM - 0 tablets
01/23/2024 12:30 AM - 6 tablets - "Investigation in process due to quantity 2 missing. [Count entered was 6 but count in system is 8.]"

Resident 3's "Incident Report," dated 01/23/2024 at 12:29 AM, signed by Administrator A, documented:
"On 01/22/2023 [sic: 2024] Monday at 7am when doing narc count, the Oxycodone card was missing.

On 01/31/2024, at approximately 1:00 PM, Surveyor interviewed Manager D. Manager D stated Resident 1's PRN Oxycodone had been placed on hold so s/he moved the blister card to the office so staff would not administer it. Manager D stated s/he was not contacted when staff were unable to locate the blister card, so they could verify the controlled substance count, until 01/23/2024. Manager D stated, "The computer system will alert staff if the count does not match the previous count." Manager D explained, "When I was contacted, I told them the card was in the office. Staff retrieved the card and found that the card only had 6 remaining tablets, when it should have had 8. We were unable to determine who dispensed the extra 2 tablets as it was determined that a master key for the office was found with a set of medication keys

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ring."

On 01/31/2024, at approximately 1:30 PM, Surveyor and Manager D observed Resident 1's Oxycodone blister card in the med cart. Manager D and Surveyor counted 6 Oxycodone tablets. Manager D stated the medication was no longer on hold.

Surveyor noted 5 shift changes occurred before Resident 1's Oxycodone blister card was located.

On 02/06/2024, Surveyor requested the police report regarding the misappropriation of Resident 3's Oxycodone. The report documented: "01/22/2024 11:45 PM - Once inside the facility, I was greeted by [Licensee A]. [S/he] had pulled up computer records outlining the timeframe that [Resident 3's] prescription was accounted for. [His/her] records indicated that [Resident 3] had 8 of [his/her] Oxycodone pills remaining at approximately 6:30 AM on Sunday 01/21/2024. This count was verified by two staff members. ... At approximately 1:30 PM, on Sunday 01/21/2024, [Manager E] removed [Resident 3's] prescription from the locked narcotic box. [S/he] then moved the prescription to the manager's office upstairs in the building. ... [Manager E] indicated that [s/he] did not complete a count of the medication at this time. The last recorded disbursement ... on 01/05/2024. Second shift staff during the afternoon of 01/22/2024 observed [Resident 3's] prescription missing from the narcotics box. They were instructed by [Manager E] to count [Resident 3's] prescription as "0" because [s/he] moved it to the manager's office. ... [Licensee A] then arrived at [home] and retrieved [Resident 3's] prescription from where [Manager E] had placed it. It was then discovered that [Resident 3's] prescription

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contained (6) 5 MG (milligram) Oxycodone pills inside of the last recorded 8."

On 02/14/2024, at approximately 1:20 PM, Surveyor interviewed Licensee A. Licensee A stated, "I worked that Sunday when the Oxycodone count was off. Staff wouldn't sign because the narcotic count was off."

On 02/19/2024, at approximately 1:00 PM, Surveyor interviewed Caregiver H. Caregiver H stated, "I refused to sign the narcotic counts because they were off."

On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Caregiver I stated, "When [Caregiver F] and I were doing shift change, we were doing the narcotic count, and I noticed there was no Oxycodone mediation in the lockbox. I asked [Licensee A] why [Resident 3's] Oxycodone still showed up in ECP (electronic computer system) if there was no medication available. [Licensee A] stated [s/he] had no idea what was going on and I was to put zero as the count. This did not sit right with [Caregiver F] and I. [Caregiver F] tried to explain the ramifications of putting incorrect information into the system when it came to narcotics. [Licensee A] stated [s/he] would look around the facility to find the missing narcotic card. About an hour later, [Licensee A] found the card, but instead of 8 tablets remaining, there were only 6. [Caregiver F] and I said an internal investigation needed to occur. [Licensee A] stated said [s/he] will do some looking and fix the system so caregivers would not encounter any conflicts of quantity changes in ECP. End of shift comes and ECP quantity was not fixed, and no caregiver wanted to take the med keys because of the liability of the missing Oxycodone."

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M 572	Continued From page 110 On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Surveyor asked if there were concerns with narcotic counts when s/he was the manager. Manager N stated, "The narc (narcotics) counts were always off. I would be looking at the schedule, trying to figure out who worked, who supposedly administered the medications, was the medication actually given, ask the residents if they received their narc. If you stated something to [Licensee A] or [Co-Owner B] they would give the same answer 'We will look into it.' You knew nothing was looked into." Manager N stated, "Often times, then [Licensee A] and [Co-Owner B] would start arguing about it and they didn't care who could hear, residents, staff, visitors." On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Surveyor asked if staff would immediately know that the narcotics count did not match the previous shifts count. AED F stated, "The electronic MAR will turn red if a staff member enters a number that does not match the last count number." Licensee A stated s/he had tried to reach Manager E, but s/he did not answer his/her phone. Licensee A stated staff should have contacted him/her immediately when the count was off. Licensee A stated a new policy had been put into place where a staff member cannot leave until all narcotic counts are accurate. Example 2: Resident 4 and Resident 6 On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver JJ and	M 572		

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previous Caregiver KK. Caregiver JJ stated that s/he oversaw the resident's petty cash. Caregiver JJ stated, "I kept it in a locked locker and never had any concerns. When we were going on vacation in June (2023), [Licensee A] stated I should give [him/her] the money, so I did. I did not think about it until I was getting ready to take some residents shopping and the petty cash was gone. [Licensee A] and [Co-Owner B] were like who had access to the office. To find out, they were letting staff, including agency staff, sleep up there because we were so short of staff and that way, they could work longer hours." Caregiver JJ stated that Co-Owner B and Licensee A were not going to report the missing money to law enforcement. Caregiver JJ stated, "They told me that if I had a problem with it, I could call law enforcement. So, I did."

On 04/09/2024, Surveyor requested reports regarding theft from the county sheriff department. The reports documented:
"06/28/2023 - Victim [Resident 4] $100; Victim - [Resident 6] $72.11"
"Upon my arrival, I met with [Caregiver JJ and Caregiver KK]. ... [Caregiver JJ] explained that each resident has a zipper bank bag that cash is kept in for their use. The cash is provided by the resident. The bags are kept track of by the staff. Typically, [s/he] said they are kept locked in a locker, with only [him/herself] and [Licensee A] having a key. ...[S/he] said that prior to [him/her] leaving for vacation, June 9th, [s/he] had a conversation with [Licensee A] about the money. [Licensee A] asked [him/her] to put the money in a cabinet in the upstairs office/apartment. ... All of the residents that had money taken have guardians, as they are not competent. I had [Caregiver JJ] fill out a written statement, and a Restitution form for each of the victims. [S/he]

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M 572	Continued From page 112 felt that [Licensee A and Co-Owner B] may be reimbursing the residents. ... [Caregiver JJ] said [s/he] was made aware several employees having access to the upstairs apartment ... They were allowed to stay in the apartment by [Licensee A]. ... [Caregiver JJ] stated ... the owners were reluctant to have this reported." "07/22/2023 - I spoke to [Caregiver JJ]. [S/he] confirmed that [s/he] still worked for [provider] and confirmed that [Licensee A and Co-Owner B] have not reimbursed the residents for their losses." On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and AED F. Co-Owner B stated immediately that the residents needed to be made whole and questioned why that had not occurred.	M 572		
M 574	88.10(3)(n)1 Freedom From Seclusion and Restraints Except as provided in subd. 2, to be free from seclusion and from all physical and chemical restraints, including the use of an as-necessary (PRN) order for controlling acute, episodic behavior. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not keep residents free from physical restraints and seclusion. Resident 3, Resident 5, and Resident 6 were strapped to a couch with a ratchet strap during a	M 574		

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parade.

Findings include:

The provider is licensed to care for up to 4 residents in the client groups of: irreversible dementia/Alzheimer's disease, physically disabled, emotionally disturbed/mental illness, developmentally disabled and advanced aged.

On 03/18/2024, Surveyor reviewed Resident 5's managed care organization (MCO) documentation provided by Care Manager (CM) GG, which documented:
"08/28/2023 Nursing Progress Note: Call with [Resident 5's Power of Attorney (POA) Y], [POA Y] received a picture of [Resident 5] being pulled on a couch on a float behind a pickup with [his/her] pajamas on in a parade. [POA Y] had not idea this was going to happen and was upset as member was in very warm pajamas and was very overheated and flushed at the end of the parade. [POA Y] has concerns about member's safety as to how [s/he] was transported and how [s/he] was strapped in on the couch."
"08/30/2023 - Provided consultation to [program supervisor], who advised member was in a parade and provider had member strapped to a couch with a ratchet strap, which member could not remove. Advised this would be an unapproved use of a restrictive measure."
"09/19/2023 - Discussion with: Legal guardian notified team of incident, working with supervisor and additional management. The member had an unplanned use of restraint. The IDTS (interdisciplinary team) will work with the Member to prevent reoccurrence."
CM GG forwarded Surveyor a copy of the parade picture. Surveyor was able to determine Resident 3, Resident 5, and Resident 6 were sitting on the

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M 574	Continued From page 114 couch, restrained with the ratchet strap. On 03/18/2024, Surveyor reviewed Resident 3's individual service plan, dated 06/01/2023, which did not document his/her cognition level to determine if s/he would be able to unsecure a ratchet strap. On 03/18/2024, Surveyor reviewed Resident 6's individual service plan, dated 04/27/2023, which did not document his/her cognition level to determine if s/he would be able to unsecure a ratchet strap. On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and AED F. Co-Owner B stated, "There was a staff member on the 4th of July float with them if they needed to remove the 'restraint.'" Licensee A stated the MCO CM was going to conduct a training on restraints for the staff.	M 574		
M 580	88.10(3)(p) Prompt and Adequate Treatment Prompt and adequate treatment. To receive prompt and adequate treatment and services appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, 1 of 1 resident (Resident 1) did not receive prompt and adequate treatment and services when s/he tried to commit suicide. Findings include: On 01/04/2024, the Department received a	M 580		

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concern alleging that residents do not receive prompt and adequate treatment during medical emergencies.

Resident 1's "Observation" notes documented:
12/06/2023 7:15 PM - Written by previous Manager N: Writer spoke to care staff. Care staff stated resident had [his/her] T-shirt wrapped around the side rail, over [his/her] body and around [his/her] neck as if [s/he] was trying to choke [him/herself]. Care staff stated that when [s/he] tried to get resident to release 4the shirt [s/he] hesitated and refused momentarily. Care staff immediately went to get management. Management came down from office to assess the resident. When management questioned the resident if [s/he] tried to choke [him/herself] resident stated that "[S/he] does know." Writer reached out to hospice to advise. As writer called hospice resident then tried to throw [him/herself] on the floor. Care staff was able to stop [him/her] from falling on the floor. When writer asked resident if [s/he] tried to fall on purpose to inflict harm on [him/herself] resident stated, "Yes." Hospice advised writer to send resident to hospital. Owner wanted hospice to come out and evaluate resident prior to sending [him/her] to hospital. Writer awaiting hospice to arrive. Owner aware.
12/06/2023 9:15 PM - Written by previous Manager N: Resident is being transferred to [hospital] for mental health evaluation.
12/07/2023 3:15 PM - Written by previous Manager N: Writer spoke to [hospital]. Hospital stated resident was admitted around 1AM today.

Police Report
12/06/2023 19:33:36 (7:33 PM) - [Resident 1] Social Worker with [Hospice]. [Resident 1] tried to commit suicide and will continue to do so.

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Happened 1 hour ago [Resident 1] tried to hang [him/herself].
12/06/2023 19:39:14 (7:39 PM) - Unknown is [sic: if] rescue is needed
12/06/2023 19:40:45 (7:40 PM) - Attempting to get into contact with [provider]
12/06/2023 19:41:01 (7:41 PM) - No answer for [provider]
12/06/2023 19:44:46 (7:44 PM) - Attempted to contact, twice with no answer
12/06/2023 19:48:00 (7:48 PM) - left vm (voicemail)
12/06/2023 21:15:53 (9:15 PM) - [Resident 1] had attempted to hang [him/herself] with [his/her] tshirt today. ... [Resident 1] has made comments of self harm, is depressed, and takes anti-depressant. ... [Hospice] had contacted us regarding the situation. ACS (adult care services) was contacted and given the facts of the matter. ... [Resident 1] voluntarily agreed to seek mental health treatment. [Rescue] responded and transported [him/her] to a hospital. ACS was notified.

On 02/13/2024, at approximately 3:50 PM, Surveyor interviewed Lead Shift Supervisor P. Lead Shift Supervisor P stated, "[Resident 1] is suicidal. [S/he] wants to kill [him/herself]. [S/he] deals with paranoia. I and [previous Manager N] called the sheriff when [previous Caregiver I] found [Resident 1] trying to hang [him/herself]. We wanted [him/herself] placed on a 72-hour hold. [Resident 1] was discolored, it wasn't attention seeking. [Co-Owner B] and [Licensee A] said it was, but it wasn't." Lead Shift Supervisor P stated, "It can be frustrating, because [Co-Owner B] always makes people look stupid. [S/he] told us that ACS had been contacted and then when the police arrived, [s/he] acted like [s/he] was shocked when the police

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commented that ACS had been notified."

On 02/14/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver CC. Caregiver CC stated, "If [Resident 1] had the opportunity, [s/he] would commit suicide."

On 02/13/2024, at approximately 1:00 PM, Surveyor interviewed Hospice Registered Nurse (RN) K and Hospice Nurse Practitioner (NP) FF. RN K stated that when s/he received the call that Resident 1 had attempted suicide, s/he took it seriously. RN K and NP FF stated SW R was contacted.

On 02/20/2024, at approximately 9:35 AM, Surveyor interviewed Hospice Social Worker (SW) R. SW R stated, "It was reported to us by [previous Manager N] that [Resident 1] was attempting suicide. [S/He] had [his/her] shirt wrapped around [his/her] neck and the bedrail and was attempting to tighten it. [Manager N] explained [Resident 1's] appearance and we wanted [him/her] sent to the hospital. [Co-Owner B] did not want [him/her] to go to the hospital, stating this is something we can handle in the home. Due to the concern, I requested a wellness check on [him/her] which involved ACS. It was concerning that [Co-Owner B] would tell staff that [Resident 1's] actions were not a concern."

On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Caregiver I stated, "I walked into [Resident 1's] room and I found [him/her] with [his/her] shirt covering [his/her] head. His face was visible and [his/her] right arm was out of its sleeve and the sleeve was wrapped around the right-side bedrail and the rest of the shirt wrapped around [his/her]

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neck. [S/he] was trying to hang [him/herself]. I got [Resident 1] to release [his/her] shirt. I immediately went to get [Co-Owner B], [Manager N], and [Lead Caregiver P]. [Manager N] told [Co-Owner B] that [Resident 1] needed to be sent out for a psych evaluation. [Co-Owner B] said no. [Manager N] called [Resident 1's] hospice nurse who stated [s/he] needed to be sent out for evaluation. [Co-Owner B] informed us that hospice contacted [him/her] and that they were on their way to assess. After about an hour we were told hospice was not coming. [Co-Owner B] had called them and said the situation was under control. The sheriff arrived; I do not know who called them. Anyways, the sheriff was talking with [Manager N] and [Co-Owner B]. [Co-Owner B] said the staff were confused on what happened and [Resident 1] did not attempt to kill [him/herself], [s/he] was just attention seeking. [Manager N] and [Co-Owner B] got into a heated argument. The sheriff must have agreed with [Manager N] because [Resident 1] was transported to the hospital for evaluation. I was told that while [Resident 1] was in the ambulance, [s/he] said [s/he] was trying to take [his/her] life.

On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed Manager N. Manager N stated Resident 1 had tried to commit suicide by tying [his/her] shirt around [his/her] bedrail and choking [him/herself]. Manager N stated, "I walked in on [him/her]. [S/He] said [s/he] was trying to kill [him/herself]. [S/He] had made threats prior to that. I tried to send [him/her] out but [Licensee A] and [Co-Owner B] said [s/he] did not need to go out. [Co-Owner B] told me I was not to call 911 until [s/he] got to the facility so [s/he] could determine if [Resident 1] needed to be sent out. I told [Co-Owner B] that I had contacted hospice, as that is protocol, and they

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M 580	Continued From page 119 want [him/her] sent out and [Co-Owner B] still did not want [him/her] sent out. Hospice stepped in and contacted the police." On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and AED F. Co-Owner B stated, "Staff was upset with me but staff didn't make it clear to me that [s/he] had attempted suicide. When I showed up and saw the t-shirt tied, I immediately requested 911." Co-Owner B stated, "I do not want staff calling 911 without my knowledge as I want to ride along with them or follow them to the hospital." Licensee A stated, "[Co-Owner B] they don't always allow you to ride along in the ambulance."	M 580		
Z 055	DHS 13.05 (3) (a) ENTITY ALLEGATION REPORTING REQUIREMENTS Entity's duty to report to the department. Except as provided under pars. (b) and (c), an entity shall report to the department any allegation of an act, omission or course of conduct described in this chapter as client abuse or neglect or misappropriation of client property committed by any person employed by or under contract with the entity if the person is under the control of the entity. The entity shall submit its report on a form provided by the department within 7 calendar days from the date the entity knew or should have known about the misconduct. The report shall contain whatever information the department requires.	Z 055		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not contact the licensing agency within 7 days when they had reasonable cause to suspect that a resident had been abused for 3 of 3 incidents. The licensee did not conduct a written investigation, as soon as possible, after being notified by staff and resident of alleged abuse and/or neglect and/or sustained injuries of unknown origin.

Resident 1 accused Co-Owner B of feeding him/her too fast.
Resident 3 was physically assaulted by Caregiver MM.
Resident 3 had his/her prescribed oxycodone misappropriated.
Resident 4's and Resident 6's petty cash was misappropriated.
Resident 5 sustained injuries of unknown origin.

Findings include:

Example 1: Resident 1

On 01/04/2024, the Department received a concern that a resident had been force fed regular food.

On 02/13/2024, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the home, 11/14/2023, with diagnoses including Parkinson's disease with dyskinesia, dystonia, muscle weakness, muscle spasm, and depression.

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Z 055	Continued From page 121 Resident 1 was on hospice. Resident 1's "Observations," dated 11/14/2023 through 02/13/2024, did not document any incidents regarding allegations of being force fed food. Resident 1's record did not contain any incident reports regarding allegations of being force fed food. On 02/13/2024, at approximately 12:00 PM, Surveyor interviewed Licensee A and Co-Owner B. Surveyor asked if they were aware of any allegations that [Co-Owner B] had force fed a resident. Co-Owner B stated, "I was informed by staff that I was feeding [Resident 1] too fast, so I stopped. I brought [him/her] beans, [s/he] loved them, [s/he] ate all of it. I just wanted to find food that would encourage [him/her] to eat." Surveyor asked which staff member told him/her Resident 1's concern. Co-Owner B stated, "I don't remember." After some time, Co-Owner B stated, "No wait, [Licensee A] told me because [previous Caregiver I] had told [Licensee A]. I immediately spoke to [Resident 1] about it. [Resident 1] denied that I had fed [him/her] too fast." Surveyor asked where this was documented and if it had been reported to the Department. Co-Owner B stated, "I do not do documentation. I assume the managers document whatever needs to be documented." On 02/13/2024, at approximately 3:50 PM, Surveyor interviewed Lead Caregiver P. Lead Caregiver P stated, "[Resident 1] told me [Co-Owner B] force fed [him/her], I informed [Caregiver I]. We discussed the concern with [Co-Owner B] who told us 'I wasn't feeding [him/her] fast.' After this, we were told by	Z 055		

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management that there are to be two staff members in [Resident 1's] room at all times, so that [s/he] cannot make accusations."

On 02/14/2024, at approximately 11:55 AM, Surveyor interviewed Co-Owner B again. Co-Owner B stated, "It was reported I fed [Resident 1] too fast. I always wait for [him/her] to signal that [s/he] is ready for another bite. [Resident 1] has a tendency to lie."

On 02/14/2024, at approximately 2:25 PM, Surveyor interviewed Manager E. Manager E stated, "[Co-Owner B] will buy food for [Resident 1] to see what foods s/he will eat."

On 02/19/2024, at approximately 1:00 PM, Surveyor interviewed Caregiver H. Surveyor asked if Resident 1 had stated Co-Owner B force fed him/her to eat. Caregiver H stated, "I don't know about that, but [Co-Owner B] would bring in food for [Resident 1]. Food that [Resident 1's] body could not digest and [s/he] would have explosive diarrhea. I would feel so bad for [him/her]."

On 02/24/2024, at approximately 5:15 PM, Surveyor interviewed Caregiver EE. Surveyor asked Resident 1 had stated Co-Owner B force fed him/her to eat. Caregiver EE stated, "[Resident 1] did not say that to me, but [Co-Owner B] would bring in milkshakes for [him/her]. [Resident 1] rarely eats and then [s/he] is given a milkshake which would cause [Resident 1] to have diarrhea all day! I just don't understand why [Co-Owner B] would do that."

On 02/26/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Caregiver I stated, "One night I was working with

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[Lead Caregiver P]. I was working with the other residents and at one point I was in one of the rooms with them and [Lead Caregiver P] just made cornbread for [Resident 1] but had to grab something from the other houses to feed [Resident 1] so there was two minutes where no caregiver was around. When [Lead Caregiver P] came back, [s/he] went in [Resident 1's] room and saw [Co-Owner B] force feeding [Resident 1] with the bed at a ninety-degree angle which is a painful position for [him/her]. [Lead Caregiver P] immediately asked what was going on. [Co-Owner B] left and [Resident 1] stated to [Lead Caregiver P] that [Co-Owner B] was choking [him/her] with the food and that [s/he] told [him/her] to stop feeding [him/her], but [Co-Owner B] wouldn't listen to [him/her]. I happened to see the last minute of this happening. [Co-Owner B] scurried out the door but [Lead Caregiver P] and I called [Co-Owner B] and [Licensee A] and we were yelling at [Co-Owner B]."

On 03/06/2024, at approximately 2:00 PM, Surveyor interviewed Resident 1. Surveyor asked Resident 1 if s/he had concerns with Co-Owner B. Resident 1 stated, "They need compassionate people here. If I don't eat, I will get kicked out." Surveyor continued to listen until approximately 2:40 PM when Resident 1 stated, "I am tired, this is all so overwhelming, I am tired."

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director (AED) F. Surveyor asked why an investigation into this concern was not completed. Co-Owner B and Licensee A stated they had talked with Resident 1 who denied the allegations, so an investigation was not needed.

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Z 055	Continued From page 124 Example 2: Resident 3 assaulted by Caregiver MM On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver JJ and previous Caregiver KK. Caregiver JJ and Caregiver KK explained that Caregiver MM had physically assaulted Resident 3 by throwing him/her into a garbage can. Caregiver KK stated, "It significantly crushed the garbage can. I took a picture of it and showed [Co-Owner B] and was told that [s/he] would take care of it." Caregiver KK forwarded Surveyor a copy of the photo. Caregiver JJ stated, "[Caregiver MM] often came to work under the influence of what appeared to be marijuana and displayed anger issues. Eventually, [s/he] was moved from working in the home, moved to a different home." Surveyor asked if an incident report was written. Caregiver JJ stated s/he had written an incident report, but Licensee A, Co-Owner B, and Manager D would review all incident reports and determine if the report should have been written. Surveyor asked when this incident occurred. Caregiver JJ and Caregiver KK stated Caregiver MM only worked a short time in early 2023. On 04/09/2024, Surveyor reviewed Resident 3's record. Resident 3's record did not contain an Incident Report in 2023 regarding the altercation. Resident 3's "Observations," dated 10/2022 to 01/2024, did not document an incident regarding an altercation between Resident 3 and Caregiver MM. On 04/11/2024, from approximately 1:00 PM to	Z 055		

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7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and AED F. Licensee A and Co-Owner B stated they were not aware of the incident. Licensee A stated Resident 3 and Caregiver MM did not get along, so Caregiver MM was moved to a different home. Licensee A stated s/he had changed incident reports in the past but not this one.

On 04/12/2024, at approximately 8:10 AM, Surveyor re-interviewed Caregiver JJ and Caregiver KK. Surveyor stated that Licensee A and Co-Owner B were not aware of this incident. Caregiver KK stated, "That is an outright lie." Caregiver JJ stated, "I was told I was not to contact [Resident 3's] family regarding the situation. The issue had been dealt with because they moved [Caregiver MM] to a different home." Caregiver JJ and Caregiver KK stated, "This is why we left employment with them. The constant covering up of concerns." Caregiver JJ stated, "I should have made a copy of my incident report. This is a lesson learned."

On 04/15/2024 at 10:32 AM, Administration C emailed Surveyor and stated Caregiver MM worked 03/03/2023 to 05/13/2023 for the provider.

Example 3: Resident 3's Oxycodone was misappropriated

On 01/04/2024, the Department received a concern that a resident's Oxycodone had been misappropriated.

On 01/31/2024, at approximately 11:30 AM, Surveyor interviewed Co-Owner B and Manager D. Co-Owner B stated that law enforcement had been contacted due to alleged misappropriation

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of narcotics. Co-Owner B stated that Resident 3's blister card of Oxycodone had been moved and unaccounted for during narcotic counts. When the card was located, 2 tablets of Oxycodone were unaccounted for. Surveyor asked if the Department had been contacted regarding the misappropriation of narcotics. Co-Owner B stated we contacted law enforcement.

On 02/14/2024, at approximately 2:25 PM, Surveyor interviewed Manager E. Manager E stated [Resident 3] hadn't been asking for the Oxycodone, so s/he removed them from the med cart, so staff would not administer them, since [Resident 3] was an opioid seeker. Manager E stated staff had commented that [Resident 3] would become more unstable when s/he took them. Surveyor asked if s/he had filed a report with the Department regarding the misappropriation of narcotics. Manager E stated that s/he had been informed that was not a requirement by Licensee A and Co-Owner B.

On 02/14/2014, at approximately 11:20 AM, Surveyor interviewed Caregiver F. Caregiver F stated, "I tried to explain to management the regulations and they do not listen, or they do not want to hear it. When the meds went missing, law enforcement should have immediately been brought in. There is no protocol. ECP (electronic computer program) will pop up red if the narcotic number you are trying to type in does not match the previous number. Staff know immediately if there is an error."

On 03/06/2024, Surveyor reviewed the Department's facility file and noted a written report had not been filed since licensure, 05/12/2020.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018014	A. BUILDING: _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTES PLACE I	1515 A HIGHWAY 175 RICHFIELD, WI 53076

(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
Z 055	Continued From page 127 Example 4: Resident 5 On 02/25/2024, at approximately 10:35 AM, Surveyor interviewed Resident 5's Power of Attorney (POA) Y. POA Y stated s/he had contacted the provider two days ago because s/he had noticed bruising on Resident 5. POA Y stated, "Of course nobody knows how it happened." On 02/26/2024, at approximately 12:30 PM, Surveyor interviewed Resident 5's managed care organization (MCO) Care Manager (CM) GG. CM GG stated, "In July there were concerns about bruising/scrapes; never did get a response regarding how that happened." Surveyor requested Resident 5's MCO records. On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Caregiver W stated Resident 5 never had bruises and now s/he does. Caregiver W stated when s/he observes concerns, s/he informs management as they are responsible for filling out incident reports. On 03/18/2024, Surveyor reviewed Resident 5's record. Resident 5 admitted to the home, 11/06/2020, with diagnoses including vascular dementia, osteoporosis, muscle weakness, and generalized anxiety disorder. Resident 5's MCO record documented: "07/13/2023 - Received call from [POA Y] stating [s/he] was visiting member 07/11/2023 and noted new bruising on wrist and scrapes on shins of member. [POA Y] asked staff about this and they were unaware of these injuries. [POA Y] shared	Z 055		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Z 055	Continued From page 128	Z 055		

photos with IDT (interdisciplinary team) of injuries for review. CM reached out to facility for more information. Awaiting response at this time."
"07/24/2023 - Social Services Progress Note: CM spoke with [Licensee A] regarding member injuries. [S/he] states this was investigated by [healthcare] RN (registered nurse). Member has been kicking more recently. RN believes [s/he] is displaying signs of restless leg syndrome, and easily could have kicked and inadvertently hit [his/her] legs on objects around the house."

Resident 5's "Observations," dated 06/01/2023 through 01/31/2024, documented:
"12/30/2023 documented by previous Caregiver I - Resident has a half dollar sized bruise on top, right elbow."
"12/31/2023 documented by previous Caregiver HH - As I was applying topic med to [Resident 5's] left arm, I noticed a bruise on [his/her] inner elbow. She did not know how it happened."
Observations did not document bruising concern mentioned in 07/2023 and/or 02/2024.

On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and AED F. Surveyor asked why concerns and/or injuries of unknown origin are not documented in a resident's record. AED F stated that s/he was working on creating a new process to reflect what staff should be documenting in the resident's record. Surveyor asked who is responsible for investigating and writing up the results of an investigation. Licensee A and AED F stated they have a better understanding of when an investigation needs to be completed and will follow through on investigations going forward.

Example 5: Resident 4 and Resident 6

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BETTES PLACE I	1515 A HIGHWAY 175 RICHFIELD, WI 53076

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Z 055	Continued From page 129 On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver JJ and previous Caregiver KK. Caregiver JJ stated that s/he oversaw the resident's petty cash. Caregiver JJ stated, "I kept it in a locked locker and never had any concerns. When we were going on vacation in June (2023), [Licensee A] stated I should give [him/her] the money, so I did. Upon my return, the petty cash funds were missing. I was informed that management was not going to report the concern, so I contacted law enforcement." On 04/09/2024, Surveyor requested police reports regarding theft from the county sheriff department which documented: "06/28/2023 - Victim [Resident 4] $100; Victim - [Resident 6] $72.11" "Upon my arrival, I met with [Caregiver JJ and Caregiver KK]. ... [Caregiver JJ] stated ... the owners were reluctant to have this reported." "07/22/2023 - I spoke to [Caregiver JJ]. [S/he] confirmed that [s/he] still worked for [provider] and confirmed that [Licensee A and Co-Owner B] have not reimbursed the residents for their losses." On 04/11/2024, from approximately 1:00 PM to 7:00 PM, Surveyor conducted the exit interview with Licensee A, Co-Owner B, Administration C, and Assistant Executive Director F (Caregiver F). Licensee A and Co-Owner B stated through this survey process they have a better understanding of when a written report should be sent to the Department. On 04/12/2024, Surveyor reviewed the Department's facility file and noted a written report had not been filed since licensure,	Z 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Z 055	Continued From page 130 05/12/2020.	Z 055		