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	0018172	A. BUILDING: _____ B. WING _____	C 04/22/2024

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M 000	INITIAL COMMENTS On 02/13/2024, with information gathered through 04/22/2024, Surveyor conducted a complaint investigation at Bettes Place 2. Twenty-four deficiencies were identified. Complaint was substantiated. Census: 4	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 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,	M 114		

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

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M 114	Continued From page 1 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 1 of 1 personnel files reviewed included a complete background check as required. The report from the Department of Justice (DOJ) criminal record, the Integrated Background Information System Letter (IBIS), and the Background Information Disclosure (BID) form were not completed within 60 days of Co-Owner B's hire date. Findings include: 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. Co-Owner B	M 114		

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M 114	Continued From page 2 stated, "After this survey process, you are right, I do provide cares to the residents."	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 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 in status for 1of 1 resident. Resident 2 was hospitalized due to a fall which resulted in a broken hip and the Department was not notified. Findings include: On 02/26/2024, at approximately 10:20 AM, Surveyor interviewed Resident 2's Power of Attorney (POA) Q. POA Q stated Resident 2 had fallen out of his/her bed and broke his/her hip. POA Q stated the provider was unable to tell him/her what had happened and how long Resident 2 had laid on the floor before staff found him/her. POA Q explained that "I understand this	M 134		

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was awhile back, I believe the previous summer, but I do not understand why I could not be given a straight answer of what happened."

On 03/06/2024, Surveyor reviewed Resident 2's record.

Resident 2 was admitted to the home, 04/22/2021, with diagnoses including traumatic brain injury, abnormality of gait, and seizure disorder.

Resident 2's "Observations," dated 01/01/2022 through 08/01/2022, did not document that s/he had experienced a fall.

Resident 2's "Incident Report," dated 06/07/2022, documented:
"Resident yelled out for someone to help [him/her]. When staff entered room resident was laying on the floor sideways with [his/her] left hip on floor. Resident was not in any pain but needed assistance up. [S/he] was able to do the full ROM (range of motion) except [his/her] right leg. [S/he] said that is frozen."
"Transferred to hospital: No"
"Did resident sustain any injuries? No"

On 02/23/2024, Surveyor requested and reviewed Resident 2's managed care organization (MCO) records from his/her Care Manager S.

Resident 2's MCO records documented:
"Date of fall: 06/10/2022, Date CCI notified of fall: 06/14/2022, Injury sustained as a result of the fall; required ER (emergency room) visit with hospital stay and surgery."

On 02/23/2024, Surveyor reviewed the department's record and did not locate a written

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M 134	Continued From page 4 report from the provider stating that Resident 2 had a change of condition that resulted in hospitalization. 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. Twenty-five deficiencies were cited. Findings include: Example 1: Training This provider is licensed to care for up to 4 residents in the client groups of: irreversible dementia/Alzheimer's disease, physically	M 216		

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disabled, emotionally disturbed/mental illness, developmentally disabled and advanced aged.

On 10/04/2023, the Department received a concern that staff were not accurately trained.

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. We are rotated through the homes, and you are just supposed to know the residents."

On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. 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. I was working on my own on day two in the home with the residents that have behaviors." Caregiver I 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 02/26/2024, at approximately 10:20 AM,

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Surveyor interviewed Resident 2's Power of Attorney (POA) Q. POA Q stated, "There is always new staff coming through the home. I want to know if they are trained to work with residents who have a traumatic brain injury. Based on how most of them react around the residents, I would say no." POA Q stated, "Staff do not know how to do observations of the residents. Why don't they assist residents with washing their hands before meals. I have seen [Resident 2] with [his/her] fingernails full of feces or on [his/her] hands, staff do nothing. [Resident 5's] [POA HH] has complained of the same concern. I spoke with [Licensee A] and [Caregiver F] about it; I even brought in hand wipes for everyone to use. I was there yesterday; they are nowhere to be found! [Resident 2's] skin is so dry. Do staff know they should be reporting this?"

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, 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 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

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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."

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?"

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 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 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver Z. Caregiver Z 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

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electronic medication administration record system. Every facility I worked at was still using paper. I had to figure it out on my own." Caregiver Z 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." Caregiver Z stated, "[Manager F] would witness staff struggling with a resident during a behavioral outburst and [s/he] would not step in and provide guidance."

On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver G and previous Caregiver K. Caregiver G stated, "Staff weren't trained on how to provide proper cares to residents. What was acceptable and what wasn't." Caregiver G and previous Caregiver K 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 G and Caregiver K. Caregiver G and Caregiver K 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 DD]. 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 and AED F. Licensee A, Co-Owner B,

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Administration C and AED F communicated amongst themselves and discussed what changes needed to occur regarding training for staff.

Example 2: Non-disclosure Form

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 02/13/2024, with information gathered through 04/22/2024, Surveyor conducted a complaint investigation. As a result of the survey, 25 deficiencies, including this one, were identified:

Licensee/Owner:
-Licensee A allowed documentation to be amended/deleted to ensure the appearance of

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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 staff members, and/or when residents sustained an injury requiring medical treatment.
-Licensee A did not investigate when residents/staff alleged misconduct by staff members 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:
-One of 4 residents did not have a room conducive to their non-ambulatory status.
- Two of 2 resident records did not include comprehensive individual service plans.
- Four of 4 residents did not receive organized activities.
- Two of 2 residents did not receive transportation to medical appointments and/or assistance during medical appointments.
-One of 1 resident edema was not monitored.
-Four of 4 residents were not offered the option to hold a key to his/her room to guarantee privacy.
-Two of 3 residents records were not reviewed with their care team or resident representatives.
-Two of 2 residents did not receive ordered physical therapy/exercises.
-Two of 2 residents had personal items misappropriated.
-One of 1 resident received delayed health

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services due to staff misconduct.

Environment:
-Licensee A did not ensure food was readily available for preparation.
-Licensee A did not ensure food was prepared and stored in a sanitary way.
-Licensee A did not ensure toxic chemical compounds were secured.

Employees:
-Two of 2 employees did not have complete background checks completed.
-One of 1 employees did not complete 8 hours of continuing education.

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 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
M0240 DHS 88.04(4)(a) Insurance - Vehicle
M0246 DHS 88.04(5)(b) Training - 8 Hours Annually
M0278 DHS 88.04(3)(b) Free of Hazards
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
M0426 DHS 88.07(1)(a) Resident Care-General

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M 216	Continued From page 12 Requirements M0430 DHS 88.07(1)(c) Activities and Services M0438 DHS 88.07(2)(b) Services Directed to Goals M0444 DHS 88.07(2)(b)3. Transportation to Medical M0448 DHS 88.07(2)(b)5. Monitoring Health M0450 DHS 88.07(2)(b)6. Notification of Changes M0470 DHS 88.07(4)(a) Nutrition M0474 DHS 88.07(4)(c) Food Prepared and Stored Sanitary Way M0482 DHS 88.09(1)(a) Resident Records M0548 DHS 88.10(3)(c) Fair Treatment M0552 DHS 88.10(3)(c) Confidentiality M0560 DHS 88.10(3)(g) Clothing and Possessions M0572 DHS 88.10(3)(m) Freedom From Abuse 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	M 230		

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residents at substantial risk of harm.

Resident 2's bed alarm was turned off which resulted in him/her sustaining falls.

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.

Example 1: Resident 2

On 10/04/2023, the Department received a concern that resident falls were not being reported.

On 02/26/2024, at approximately 10:20 AM, Surveyor interviewed Resident 2's Power of Attorney (POA) Q. POA Q stated, "I was asked to purchase a chair alarm and a bed alarm. I have no idea if they are actually being used. One time they said the chair alarm did not work. I take it to get repaired and bring it back. The very next day I find it on the floor. No wonder it doesn't work!"

On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Surveyor asked Caregiver M if Resident 2's chair and bed alarms were utilized. Caregiver M stated, "[His/her] falls are due to [him/her] getting out of bed on [his/her] own, self-transferring. [S/he] has had so many falls. The bed alarm was a new thing just before I left; they should have

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gotten it long ago. [Resident 2] refuses to ask for help so you have to keep checking on [him/her]. It was an unsafe situation."

On 03/02/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver L. Surveyor asked if staff were utilizing [Resident 2's] bed and chair alarms. Caregiver L stated s/he knew that Resident 2 had the alarms. Caregiver L stated s/he didn't know operate the alarms and had not seen Resident 2 operate the alarms.

On 03/02/2024, at approximately 11:10 AM, Surveyor interviewed Caregiver U. Surveyor asked if staff were utilizing [Resident 2's] bed and chair alarms. Caregiver U stated s/he knew that Resident 2 had the alarms. Caregiver U stated s/he didn't know operate the alarms and had not seen Resident 2 operate the alarms.

On 03/02/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver L. Surveyor asked if staff were utilizing [Resident 2's] bed and chair alarms. Caregiver L stated s/he knew that Resident 2 had the alarms. Caregiver L stated s/he didn't know operate the alarms and had not seen Resident 2 operate the alarms.

On 03/02/2024, at approximately 11:10 AM, Surveyor interviewed Caregiver U. Surveyor asked if staff were utilizing [Resident 2's] bed and chair alarms. Caregiver U stated s/he knew that Resident 2 had the alarms. Caregiver U stated s/he didn't know operate the alarms and had not seen Resident 2 operate the alarms.

On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Surveyor asked Caregiver W if Resident 2's chair and bed alarms were utilized. Caregiver W stated, "I am

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not sure, I just know one roll and [s/he] will fall out of bed. I told [Licensee A] and [Co-Owner B] and they just say, 'We will figure something out.'"

On 03/06/2024, at approximately 1:25 PM, Surveyor interviewed Resident 2. Surveyor asked if staff were utilizing his/her bed and chair alarms. Resident 2 stated, "They turn my bed alarm off at night."

On 03/06/2024, at approximately 1:25 PM. Surveyor interviewed Caregiver X. Surveyor asked if staff were utilizing his/her bed and chair alarms. Caregiver X stated, "I usually work morning shifts. I would have situations where I would walk into [Resident 2's] room and [s/he] would be trying to self-transfer or even be on the floor. No alarms going. You look and here the alarm is turned off." Caregiver X stated s/he did not recall the exact dates when s/he had found Resident 2 on the floor.

Resident 2's observation notes, dated 08/01/2023 to 02/15/2024, documented:
01/30/2024 - During round check [Resident 2] was in [his/her] recliner but [his/her] chair alarm was not under [him/her], it is required that [s/he] has it at all times during transfers."
02/05/2024 - [Resident 2] has 2 alarms [his/her] [mom/father] bought new batteries. 1 stays in [his/her] bed and the other stays in [his/her] chair.
The observation notes did not document that Resident 2 disengaged his/her bed and/or chair alarms.

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). Licensee A stated s/he

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did not realize Resident 2's alarms were being disengaged and would discuss the concern with staff.

Example 2: Illegal Drugs

On 10/04/2023, the Department received a 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."

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M 230	Continued From page 17 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 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	M 230		

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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 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

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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 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

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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 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

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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
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."

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M 230	Continued From page 22 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 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	M 230		

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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 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,

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M 230	Continued From page 24 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 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 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	M 240		

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condition on a form provided by the licensing agency.

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the home did not ensure every service provider (Caregiver Z, Caregiver G, and Caregiver K) 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 Caregiver Z. Surveyor could overhear Caregiver Z speaking with the passenger in his/her car, making comments, the brakes won't release. Surveyor asked if we should speak another time. Caregiver Z 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 Z stated s/he was ready. Surveyor asked if s/he had been asked to transport residents in his/her own personal vehicles. Caregiver Z stated, "Yes! And as you can tell, I don't have the most reliable vehicle."

On 04/09/2024, at approximately 3:00 PM,

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M 240	Continued From page 26 Surveyor interviewed previous Caregiver G and previous Caregiver K. Surveyor asked if they were asked to transport residents in their own personal vehicles. Caregiver K 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 4] to a dialysis appointment." Caregiver G 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." On 04/10/2024, Surveyor requested Caregiver Z's, Caregiver G's, and Caregiver K'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 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 in their own vehicles. Administration C stated the provider's insurance included a rider to cover staff if they did use their own vehicle.	M 240		

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M 240	Continued From page 27 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 1 of 1 staff member1 (Co-Owner B) 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: 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. On 02/16/2024 at 9:53 AM, Surveyor emailed Licensee A and Administration C and requested	M 246		

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M 246	Continued From page 28 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, 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. Co-Owner B stated, "After this survey process, you are right, I do provide cares to the residents."	M 246		
M 278	88.05(3)(b) FREE OF HAZARDS The home shall be free from hazards and kept uncluttered and free of dangerous substances, insects and rodents. This Rule is not met as evidenced by: Based on observation and interview, the provider did not safeguard 4 of 4 residents from environmental hazards. Toxic chemicals were not securely stored. Findings include: The licensee can provide cares for up to 4 residents in the client groups: irreversible	M 278		

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dementia/Alzheimer's, advanced aged, physically disabled, emotionally disturbed/mental illness, and developmentally disabled.

On 03/06/2024, at approximately 1:00 PM, Surveyor toured the environment and observed the following cleaning compounds unsecured in the kitchen sink cabinet:
-32 ounce bottle of urine destroyer
-32 fluid ounce bottle of streak-free window cleaner
-(2) Gallon jug of bleach
-26 fluid ounce bottle of brilliant bath foaming cleaner
-22 fluid ounce bottle of all-purpose cleaner
-32 fluid ounce bottle of toilet bowl cleaner
-28 fluid ounce bottle of bleach
-32 fluid ounce bottle of stain remover
-14.5 ounce can of oven cleaner

Residents were observed ambulating freely throughout the home.

Surveyor had discussed this concern on 01/31/2024, at approximately 2:45 PM, with Manager C and Manager D. Manager D stated s/he would inform the maintenance staff that a lock would need to be added to the kitchen sink cabinet.

Surveyor had discussed this concern on 02/13/2024, at approximately 2:45 PM, with Manager D. Manager D stated s/he would inform the maintenance staff that a lock would need to be added to the kitchen sink cabinet.

Surveyor reviewed his/her interviews to determine if a resident would be at risk if they had access to cleaning compounds/chemicals:
On 02/24/2024, at approximately 5:15 PM,

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M 278	Continued From page 30 Surveyor interviewed Caregiver T. Caregiver T stated, "[Resident 7], who was always allowed to wander throughout the home, will grab vases, broomsticks, anything [s/he] can get [his/her] hands onto to use as a weapon." On 02/25/2024, at approximately 9:45 AM, Surveyor interviewed previous Caregiver J. Caregiver J stated, "[Resident 7] is extremely combative. Yeah, [s/he] will use whatever [s/he] can get [his/her] hands on to to harm another person. [Resident 7] was allowed to wander through all homes." On 04/09/2024, Surveyor reviewed Resident 7's managed care organization (MCO) records provided by his/her Care Manager (CM) S which documented: "06/01/2023 - Has continuous or unpredictable behavior while awake, 1:1 staffing required continuous or immediate intervention constitutes a risk to the health and safety of the Member or others ..."	M 278		
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.	M 406		

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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 resident (Resident 1 and Resident 3) records reviewed were developed together with the placing agency, the person being admitted or person's guardian / designated representative and the provider.

Findings include:

On 02/17/2024, Surveyor reviewed Resident 1's and Resident 3's record.

Example 1: Resident 1

Resident 1 moved into the home, 02/14/2023, and his/her representative was activated Power of Attorney (POA) D.
Resident 1's ISP, dated 11/07/2023, did not contain POA D's signature.
Surveyor noted the ISP should have been completed in 08/2023.

On 02/23/2024, at approximately 10:55 AM, Surveyor interviewed POA C. POA C stated s/he could not remember if s/he had been asked to sign Resident 1's ISP in July but knew s/he had been asked to sign or review the ISP dated 02/13/2024 (during the survey process).

Example 2: Resident 3

Resident 3 moved into the home, 11/17/2022, and his/her representatives were POA FF and managed care organization (MCO) Care Manager GG.
Resident 3's ISP, dated 06/07/2023, did not contain POA FF's signature.
Resident 3's ISP, dated 12/05/2023, did not

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M 406	Continued From page 32 contain POA FF's or CM GG's signature. 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: 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's assigned room was not conducive to his/her non-ambulatory status. Findings include: On 02/13/2024, the Department received a	M 408		

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concern alleging that a resident slept half in his/her bed and half in his/her wheelchair creating a condition of risk.

On 02/19/2024, at approximately 7:50 AM, Surveyor interviewed Manager E. Surveyor stated that s/he had received a concern regarding Resident 1's sleeping pattern. Manager E stated, "The care team has been assessing [Resident 1's] sleeping arrangement. [S/He] does sleep with [his/her] legs resting on [his/her] wheelchair otherwise [s/he] has to wait for staff to assist [him/her] when [s/he] wants to get up. If [his/her] legs are on the wheelchair, [s/he] can sit up on [his/her] own. [Resident 1] has stated that the pole by [his/her] bed makes it difficult to move around in [his/her] bed. I discussed my concerns with [Co-Owner B] who stated that [Resident 1] likes the pole because [s/he] can use it to move around in [his/her] bed."

On 02/19/2024, at approximately 1:00 PM, Surveyor interviewed Caregiver H. Caregiver H stated, "[His/Her] room is too little. [S/He] tries to be independent, especially with toileting. [S/He] slides out of bed due to the way [s/he] sleeps." Caregiver H stated, "[Resident 1] will always tell you everything is okay. It's fine."

On 02/23/2024, at approximately 10:55AM, Surveyor interviewed Resident 1's Power of Attorney (POA) D. POA D informed Surveyor that s/he sleeps half on [his/her] bed with [his/her] legs resting on [his/her] wheelchair. [S/He] is unable to bend [his/her] left leg. Surveyor discussed concerns with [him/her] sliding out of bed and if Resident 1 was able to utilize the pole next to his/her bed to assist him/her in his/her mobilization. POA D stated, "That room is so small. I am not even sure where the bed could

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go, and I can't say if the pole is helping the situation with [him/her] not being able to bend [his/her] leg. I do know, [Licensee A] wants me to buy [Resident 1] a lift chair for [him/her] to sleep in. [S/he] had a hospital bed that was helpful, but I was not allowed to move it into the home." POA D stated, "[Resident 1] is just a kindhearted soul who will never complain about anything. [S/he] says [s/he] will tell you 'Big [boys/girls] do not cry.'"

On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Caregiver I stated, "The pole blocks [his/her] legs if [s/he] tries to swing them into/out of [his/her] bed. [His/Her] legs are heavy, and it is a complicated move under normal circumstances."

On 02/24/2024, at approximately 5:15 PM, Surveyor interviewed Caregiver AA. Caregiver AA stated, "[Resident 1], the way [s/he] sleeps in [his/her] bed - oh man - [s/he] is a big [person]. That is a twin sized bed; s/he needs a full-size bed at least. [S/he] can't bend [his/her] leg so he just lets that leg stay in the wheelchair. I don't recall seeing [him/her] use the pole to help [him/her] in and out of bed."

On 02/25/2024, at approximately 9:45 AM, Surveyor interviewed previous Caregiver J. Caregiver J stated the pillar in [Resident 1's] room used to be a lot bigger but had to be changed because it was too big, but it has to be there because it holds up the steps. The ceiling in [his/her] room is really low. There really isn't much turning space for [him/her] to get to [his/her] closet." Caregiver J stated, "I can imagine [Resident 1] had problems getting in and out of [his/her] bed as [s/he] is unable to move one of [his/her] legs." Caregiver J stated

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M 408	Continued From page 35 Resident 1 will never tell you if s/he had a concern. On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Caregiver M stated, "The wall is so low, [s/he] doesn't have room. You should have a big enough room so that you can get the appropriate size bed. That room is big enough for an office, not a person with a wheelchair." Caregiver M explained, "The way [s/he] sleeps; half [his/her] body is on the bed, [his/her] feet will be in the wheelchair. This can't be safe. [S/he] cannot fit in [his/her] bed." Caregiver M stated, "[S/he] is just so sweet, [s/he] will never speak up. [S/he] doesn't want to worry anybody." On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Manager N stated, "[Resident 1] needs a hospital bed but whenever I suggested it, it would get swept under the rug. I truly feel that [Resident 1] is like the black sheep of the building; [s/he] doesn't get the proper care that [s/he] needs." Manager N stated, "The room is too small, it is like a walk-in closet. [S/he] has the smallest room in the house and then there is a pole in the middle of it!" On 03/02/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver L. Caregiver L stated, "[His/her] room is very small and has a pole in the middle of it, looks like a storage unit. I tell [him/her] this is not okay and [s/he] will be like 'that's fine, that's okay;' No it isn't! [S/he] never wants to be a bother to anybody." Caregiver L stated, "[S/he] is like a bridge from the chair to the bed; [s/he] cannot be getting a good night's sleep."	M 408		

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M 408	Continued From page 36 On 03/02/2024, at approximately 11:10 AM, Surveyor interviewed Caregiver U. Caregiver U stated, "[Resident 1's] room is small, considering [s/he] has a wheelchair, it may not be the best fit for [him/her]. The pole in the room makes the room feel smaller." Caregiver U stated, "[Resident 1] always says everything is fine." On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Caregiver W stated, "One roll and [s/he] will fall out of bed. If you say something to management, they will just tell you, 'We will figure something out.' [His/Her] room is too small and [s/he] doesn't have room to maneuver in it." On 03/06/2024, at approximately 1:45 PM, Surveyor observed Resident 1's bedroom. Resident 1 was sitting in his/her wheelchair, facing his/her bed, with his/her television hanging to his/her left, at the end of the bed. The room contained a slanted ceiling and a pole in the center of the room. Resident 1's bed was horizontal with the slanted ceiling; the center of the bed was approximately 12 inches from the pole. Surveyor reviewed Resident 1's "Initial Assessment," dated 02/14/2023, which documented that Resident 1 was partially blind out of the left eye. Resident 1's closet rod was at the standard height utilized by an individual who was ambulatory. On 03/06/2024, at approximately 3:35 PM, Surveyor interviewed Licensee A. Licensee A stated that Resident 1 used the pole to help [him/herself] transfer but that s/he was working with POA D to get Resident 1 a lift chair so s/he would not be utilizing the bed any longer. Surveyor stated that staff expressed concerns	M 408		

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regarding the size of Resident 1's room and his/her sleeping arrangement. Licensee A stated it was what Resident 1 wants.

On 03/06/2024, Surveyor reviewed the provider's department file. The home was licensed on 08/27/2020, to serve up to 4 non-ambulatory residents. The floor plan on file, received on 06/08/2020, indicated Resident 1's bedroom contained 110 SF.

On 03/08/2024, at approximately 10:45 AM, Surveyor interviewed Caregiver V. Caregiver V stated Resident 1 will always say, "It's okay!"

On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver Z. Caregiver Z stated, "[Resident 1's] room is awful. The pole blocks [his/her] ability to watch [his/her] tv clearly or to be able to play [his/her] video games. I have never seen [him/her] use that pole to assist [him/herself]."

On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver G and previous Caregiver K. Caregiver G and Caregiver K stated, "[S/he] can't even move around in that room. Nobody wants that room because of the pole and since [Resident 1] will say everything is okay, to everything you ask, [Co-Owner B] and [Licensee A] leave [him/her] in 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 and AED F measured the space in Resident 1's room, starting at the 7-foot ceiling height against the slanted wall. By doing this, the

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M 408	Continued From page 38 room did not measure 100 square feet. Co-Owner B stated we were measuring it wrong. Co-Owner B stated we needed to start at the 5-foot height mark (which was an indent/cut out in the slanted ceiling that did not create any additional usable floor space, as the bed still sat along the slant). Also, the room contained additional non-usable space as there was a narrow passage next to the slant that was counted into the floor space, which could not be utilized by Resident 1. The flooring under the closet was counted as part of the usable floor space since the closet wall did not go to the floor and did not contain a door. Licensee A stated, based on the CAD drawing, a 5'2" to 5'6" wheelchair radius was available in the room. Surveyor asked Co-Owner B if s/he felt that this room was conducive to Resident 1's needs and non-ambulatory status. Co-Owner B stated, "The room was approved by the state." On 04/12/2024 at 7:09 PM, Co-Owner B emailed Surveyor with the CAD drawing of Resident 1's room. Surveyor noted the wheelchair radius, with the door open, consumed all available floor space. Co-Owner B stated, "When you were here for Thursday's inspection,(as I expressed to you then) this was the first time that you (or any inspector) had pointed out that you felt this bedroom was not suitable for it's current resident. I took another look at the room and I do not disagree with you."	M 408		
M 410	88.06(3)(d) INDIVIDUAL SERVICE PLAN The individual service plan shall contain at least the following:	M 410		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the individual service plan (ISP) was updated to reflect the change in needs for 2 of 3 residents reviewed.

Resident 1's ISP was not updated to reflect s/he was a fall risk and outline care guidelines for his/her fall interventions and incontinence.

Resident 2's ISP was not updated to reflect s/he was a fall risk and outline care guidelines for his/her fall interventions.

Findings include:

On 02/13/2024, the Department received a concern alleging residents were fall risks and precautions were not put into place.

Example 1: Resident 1

On 02/17/2024, Surveyor reviewed Resident 1's record.

Resident 1 moved into the home, 02/14/2023, with diagnoses including traumatic brain injury, muscle weakness, epileptic syndromes with complex partial seizures, idiopathic peripheral autonomic neuropathy (nerve damage), and unsteadiness on feet.

Resident 1's incident reports documented:
"07/29/2023 4:28 AM - Resident was found in a sitting position on the floor in bathroom. Resident stated [s/he] slid to the floor but did not fall no

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M 410	Continued From page 40 injuries ..." "08/03/2023 8:37 PM - Resident was found in sitting position on the bathroom floor ..." "11/08/2023 3:12 PM - Upon entering room when performing start of shift checks, writer found resident on floor on [his/her] buttocks in sitting position in front of [his/her] wheelchair." "12/31/2023 3:27 PM - [Resident 1] was trying to get back inside of [his/her] chair but slide [sic: slid] down out of [his/her] chair softly trying to stop [his/her] fall." Resident 1's progress notes documented the following fall concerns: "03/15/2023 - Resident slid out of bed last night and slid on butt" "03/24/2023 - Resident stated that [s/he] fell last night around 10PM while getting ready to go to bed ..." "05/07/2023 - Resident slipped out of wheelchair but got [him/herself] back into [his/her] wheelchair. [S/he] did not call for help. [S/he] just told staff." "01/14/2024 - Resident's legs are swollen, especially the right leg. Resident can't get [his/her] legs up in bed without help. Resident nearly fell to floor from bed because [s/he] is having a harder time lifting up [his/her] legs to wheelchair." Resident 1's progress notes documented the following incontinence concerns: "03/24/2023 - Resident woke up around 5AM and [s/he] was wet ..." "06/03/2023 - Resident wet [him/herself] and had urine all across the floor from bedroom to bathroom. Resident didn't ask for help. Staff had to assist [him/her]." "07/11/2023 - Resident soaked through [his/her] pants and wet all over the floor."	M 410		

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M 410	Continued From page 41 "07/12/2023 - Resident purposely and deliberately urinated all over the floor. Resident urinated all over bathroom floor and into the hallway." "07/14/2023 - Resident urinated all over [his/her] bed and on [his/her] bedroom floor ... There was a trail of urine from [his/her] room half way to the bathroom. Resident did not call out for help. ... Resident is not able to hold bladder long enough to make it to the bathroom." "08/02/2023 - Resident woke up around 5AM had accident on the way to bathroom. Urine all over the floor and all over [him/herself]." "08/30/2023 - Resident wet [his/her] entire bed." "09/11/2023 - Resident got up this morning and staff asked [him/her] if [s/he] needed help getting to the bathroom. Resident replied "no" but then purposely went all over the floor." "09/23/2023 - [Resident 1] slept throughout the whole night did awake due to wetting the bed ... Resident seems to become more incontinence." "09/25/2023 - Resident has been wetting [his/her] bed daily. ... Briefs were all over resident's floor." "09/27/2023 - [Resident 1] has been waking up every morning due to [him/her] using the bathroom on [him/herself]." "11/07/2023 - Wet [his/herself] and refuse staff help came out the bathroom naked" "11/21/2023 - West [his/herself] refused help" "01/14/2024 - Resident will need closer observation and help with [his/her] toileting. [S/he] can't seem to bend [his/her] swollen leg to stand up to urinate in toilet." Resident 1's "Initial Assessment," dated 02/14/2023, completed by Manager E, documented: "Toileting: Requires staff monitoring, verbal prompts and cues with toileting needs. 1 person required for the task." "Mobility & Transferring: Requires monitoring and	M 410		

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cues while transferring. Resident can get up and slide feet. 1 person required for the task." "Physical Disabilities: Resident's left leg does not bend. Wound care nurse comes to assist."

Resident 1's ISP, dated 07/08/2023, completed by Licensee A, documented the same language as his/her initial assessment, dated 02/14/2023.

Resident 1's "6 Month Assessment," dated 11/07/2023, completed by Manager D, documented the same language as his/her ISP, dated 07/08/2023.

Resident 1's ISP, dated 02/13/2024 (date of survey), completed by Licensee A, documented: "Toileting: Requires full assistance including physical and verbal assistance with toileting needs. 1 person required for the task." "Mobility & Transferring: Requires monitoring and cues while transferring. Resident can get up and slide feet. 1 person required for the task." "Physical Disabilities: Resident's left leg does not bend. Wound care nurse comes to assist."

Surveyor noted the ISPs and assessments completed did not address Resident 1's toileting behaviors and provide guidelines on proper cares and did not address Resident 1's repeated unwitnessed falls.

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 AED F would be reviewing the resident ISPs and ensuring they were individualized.

Example 2: Resident 2

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M 410	Continued From page 43 On 03/02/2024, Surveyor reviewed Resident 2's record. Resident 2 moved into the home, 04/22/2021, with diagnoses including peripheral vascular disease (circulation disorder), arthritis, abnormality of gait, muscle weakness, traumatic brain injury, seizure disorder, and hypertrophy of prostate (blockage of urine). Resident 2's "6 Month Assessment," dated 06/06/2023, documented: "Mobility and Transferring: Mobility & Walking - Monitor & Cue: Monitor that they are walking properly and comfortably. Give resident verbal prompting and encouragement as needed. Resident must use a walker. Remind resident to use a walker should [s/he] forget. [S/he] may forget and staff need to point where [his/her] room or bathroom is located if needed. Residents Needs/Preferences: Requires full assist and cues while mobile/walking. Resident uses wheelchair and does little to no walking." Transferring - Monitor & Cue: Full assistance with all transfers. Resident's Desired Goals & Outcomes: To maintain weight on [his/her] feet when transferring. Resident 2's "6 Month Assessment," dated 12/27/2023, documented: "Mobility and Transferring: Mobility & Walking - Monitor & Cue: Monitor that they are walking properly and comfortably. Give resident verbal prompting and encouragement as needed. Resident must use a walker. Remind resident to use a walker should [s/he] forget. [S/he] may forget and staff need to point where [his/her] room or bathroom is located if needed.	M 410		

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Residents Needs/Preferences: Requires full assist and cues while mobile/walking. Resident uses wheelchair and does little to no walking." Transferring - Monitor & Cue: Monitor safety and provide cues and encouragement when needed. Resident's Desired Goals & Outcomes: To transport safely/efficiently from place to place with monitoring/cues from staff."

Resident 2's "Observation" notes, dated 08/01/2023 to 02/15/2024, documented:
09/06/2023 - I was doing my 2-hour checks and [Resident 2] slide on the floor to stretch ... as a team we should check on [him/her] more and please keep [his/her] door open ...

Resident 2's "Incident Reports," documented:
"06/07/2022 7:22 AM - Resident yelled out for someone to help [him/her]. When staff entered room resident was laying on the floor sideways with [his/her] left hip on floor. Resident was not in any pain but needed assistance up. [S/he] was able to do the full ROM (range of motion) except [his/her] right leg. [S/he] said that it is frozen. Resident stated that [his/her] right leg froze up and [s/he] slipped and fell. Floor was slippery at the time of fall."
"12/28/2022 6:45 PM - [Resident 2] was trying to get ice from the refrigerator. [His/Her] walker's break [sic: brake] was not locked tight. [Resident 2] lost [his/her] balance and fell backwards."
"08/03/2023 6:24 AM - Staff took resident to restroom, sit resident on toilet. Staff went to get a garbage bag returned to restroom resident was on the floor."
"11/16/2023 9:29 AM - I was finishing up medication pass and found the individual on the floor I asked how it happened the individual said [s/he] took [his/her] blanket slide to the floor on [his/her] butt because [s/he] didn't know the staff

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name."

On 02/23/2024, Surveyor requested and reviewed Resident 2's MCO documentation, dated 06/2022 through 01/2024, from CM S, which documented: "Concern for overall safety when alone or in community due to decision making skills: Support provided for safety concern(s): Due to cognitive impairment member should be with AFH (adult family home) staff or family while out in community."

"Date of fall: 05/29/2022, Date CCI notified of fall: 06/14/2022, Injury sustained as a result of the fall; no injury, Location of fall: Bedroom, and Description of fall: Unwitnessed; member presented free of injury. Falls risk agreement not in place."
"Date of fall: 06/10/2022, Date CCI notified of fall: 06/14/2022, Injury sustained as a result of the fall; required ER (emergency room) visit with hospital stay and surgery."
"Care Management: Date of Admission - 06/11/2022. Reason for Admission - Post fall-broken hip. Date of Discharge: 06/18/2022."
"Date of Fall: 12/20/2022. Member had 1 fall on this day, Injury sustained as a result of the fall: no injury, Location of fall: bathroom, and Description of fall: Member was left alone to brush [his/her] teeth in the bathroom. Member attempted to get up on [his/her] own and fell on [his/her] left elbow. No injury. Falls risk agreement not in place."
"Date of Fall: 12/28/2022. Member had 1 fall on this day, Injury sustained as a result of the fall: no injury, Location of fall: kitchen, and Description of fall: Member stood up to get ice from the refrigerator and member's walker breaks [sic: brakes] were not locked tight. Member fell backwards on caregiver and hit [his/her] bottom

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on the floor. EMS (emergency medical service) was called and evaluated member, member refused to be transported to the hospital, no visible injury. Falls risk agreement not in place." "Date of Fall: 01/30/2023. Received 02/03/2023. Member had 1 fall on this day, Injury sustained as a result of the fall: no injury, Location of fall: hallway, and Description of fall: Member got up to use the bathroom by [him/herself]. Member used a wheelchair for balance and walked behind it. Member stated [his/her] foot slipped and sat down on the floor so that [s/he] would not fall. Member called out to caregiver to help up. Falls risk agreement not in place. Interventions in place to prevent falls: AFH gave member a call bell and has been instructed to use it any time."

On 02/26/2024, at approximately 12:30 PM, Surveyor interviewed CM S. CM S stated, "We were not informed when [Resident 2] broke [his/her] hip. This has been an ongoing problem. When we ask for an incident report regarding an incident or a fall, we are unable to get one. We found out about [Resident 2's] broken hip when [his/her] POA contacted us. Our records will only document what falls have been reported to us."

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 stated AED F would be reviewing the resident ISPs and ensuring they were individualized and identifying if they were a fall risk and what additional guidance was required.

Cross Reference: M0450 DHS 88.07(2)(b)6. Notification of Changes

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M 426	88.07(1)(a) RESIDENT CARE-GENERAL REQUIREMENTS The licensee shall provide a safe, emotionally stable, homelike and humane environment for residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a safe, emotionally stable environment for 1 of 1 resident. Co-Owner B's interactions with Caregiver AA and Resident 3 resulted in a resident-to-staff altercation. Findings include: On 02/14/2024, at approximately 12:00 PM, Surveyor interviewed Co-Owner B. Surveyor asked Co-Owner B what his/her role was. Co-Owner B stated, "I am the eyes and the ears of the place. I am the social person. I feel the mood throughout the building." Surveyor asked how Co-Owner B addressed concerns that were brought to him/her. Co-Owner B stated, "If a staff member or a resident bring a concern, I immediately tell them to stop and bring in another person, usually the manager, to listen to the concern, 3 way calls often. I expect managers to write incident reports and to start internal investigations." On 02/24/2024, at approximately 5:15 PM, Surveyor interviewed Caregiver AA. Caregiver AA stated s/he had been asked to assist with coverage in the home the day before (02/23/2024). Caregiver AA stated, "[Resident 3]	M 426		

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and I have always gotten along, and I have never had concerns with [Resident 3]. I try to get to know my residents and know what their triggers are. Anyways, [Resident 3] needed help in the bathroom, but I was burning the food in the kitchen, plus I was dealing with two homes [There are 3 homes located at this address] and then [s/he] was upset because I had left the bathroom door open a crack so I could still put eyes/ears on [him/her] and hear [him/her]. We talked it out, [s/he] was good, we had dinner, played cards, everything is good. I go back to my original home and [Co-Owner B] yelled down to me and said, 'come say "Hey" to [Resident 3].' I'm like, I was just with [him/her] for 8 hours, why should I say 'Hey!' I'm like [Co-Owner B] that is not sitting right with me. [Co-Owner B] is saying [s/he] just wants to give you a friendly 'hey!' Then I am in [Resident 3's] room and I'm like 'Hey [Resident 3], What is up!' [Resident 3] just starts yelling at me and attacks me and [Co-Owner B] is like you are up here because of the incident. [Co-Owner B] blocked me from leaving the room; [s/he] watched me get struck by the resident. [Co-Owner B] set me up. I was so upset, I didn't know what to do, I didn't know how to protect myself. Then, [Co-Owner B] provides transportation for me to get to and from work, so as we are driving home, [s/he] is like I didn't see [him/her] strike you. [Co-Owner B] is trying to tell me this is the first time [Resident 3] has ever struck out at a caregiver. Wrong! I have watched [him/her] strike other caregivers [Caregiver L]. Now [Co-Owner B] is questioning if I should come back because [Resident 3] will become upset when [s/he] sees you. I am good about going back. I was just taken by surprise and yes, I was extremely upset. I am yelling and crying because I felt like [Co-Owner B] was setting me up. Another resident (Resident 5) was in the area, so

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I walked outside, because I did not want to upset the residents any further. I said I was going home, and [Co-Owner B] is like you can't go home, you have residents to take care of. Now [s/he] is saying maybe you shouldn't come back?? I told [Assistant Executive Director F] and s/he stated the cops should have been called and that I need to tell [Licensee A] what happened. Like what good is that going to be. [Licensee A] and [Co-Owner B] are married." Caregiver AA forwarded the text message communication between her/himself and Co-Owner B after the altercation which documented:
02/24/2024 9:56 AM Co-Owner B texted Caregiver AA - Do you think that with what happened yesterday, that it is a good idea for you to come into [home] so soon?
02/24/2024 9:57 AM Caregiver AA texted Co-Owner B - Yes, because that happened yesterday we leaving it was yesterday all residents have they [sic: their] days! I was just upset because I got walked in that not knowing what was going on if I knew the problem was I would knew how to handle things I would not have walked all the way into [his/her] room I would of kept dista (distance).
02/24/2024 10:23 AM Co-Owner B texted Caregiver AA - Well ...no one expected [him/her] to act that way. [S/he] was not that agitated when I spent 15 minutes with [him/her] getting [his/her] shower story. It was not expected by anyone to be a surprise. Your explanation to me about what happened seemed to excellerate [sic: accelerate] [him/her] becoming upset. Hindsight is always easy ..."

On 02/25/2024, at approximately 9:50 AM, Surveyor interviewed previous Caregiver J. Caregiver J stated [Co-Owner B] had been known to agitate [Resident 3]. Caregiver J stated,

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"[Co-Owner B] has been known to take facts and twist them to [his/her] direction."

On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Surveyor asked Caregiver M if s/he had heard any incidents where Resident 3 had become physical towards a caregiver. Caregiver M stated, "[Resident 3] is known for [his/her] outbursts. The problem is, s/he will remember something from two weeks ago but think it just happened right now and then [s/he] will have an outburst. It isn't necessarily that staff persons fault, it could be something else making [him/her] mad."

On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Manager N stated, "[Resident 3] has behaviors; anything can trigger [him/her]. It takes nothing to set [him/her] off, it wouldn't matter what you did. [Co-Owner B] doesn't understand the resident's and their behaviors."

On 03/02/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver L. Surveyor asked Caregiver L if s/he had heard any incidents where Resident 3 had become physical towards a caregiver. Caregiver L stated, "Yeah, I heard there was an incident involving [Resident 3] and [Caregiver AA]. More than likely, [Co-Owner B] riled up [Resident 3] and expected [Caregiver AA] to handle it. That is so [Co-Owner B]. [Co-Owner B] tries to act like [s/he] is everyone's buddy, but [s/he] doesn't understand the residents and their behaviors and when they act out, it is always the staff member's fault. It is never [his/her] fault."

On 03/02/2024, at approximately 10:35 AM, Surveyor interviewed previous Caregiver O.

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M 426	Continued From page 51 Caregiver O stated, "[Co-Owner B] doesn't agree with staff on most things. Basically, it is [his/her] way or no way. Makes staff look like they do not know what they are doing." On 03/04/2024, at approximately 5:30 PM, Surveyor interviewed Caregiver W. Caregiver W stated, "If they (Licensee A and Co-Owner B) are in trouble, they will blame it on someone else." On 03/08/2024, at approximately 10:45 AM, Surveyor interviewed previous Caregiver V. Caregiver V stated, "If you say something that they don't want to hear they are going to find a reason to dismiss you." On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver Z. Caregiver Z stated, "[Co-Owner B] could say things that would trigger a resident. Then [s/he] would blame it on someone else." On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver G and previous Caregiver K. Caregiver G and Caregiver K stated [Co-Owner B] would not step in to defend a staff member. On 04/09/2024, Surveyor reviewed Resident 3's record. Resident 3's "Observations," dated 11/20/2023 to 02/01/2024, documented: 11/20/2023 - Had an episode about sleeping in [his/her] chair. I told [him/her] no one will take [his/her] chair and [s/he] can keep it. [S/he] punch the all [sic]. I told [him/her] [s/he] scaring me and [s/he] said that what [s/he] want to do because nobody going to hell [him/her] what to do.	M 426		

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12/24/2023 - Had an small episode over a sock that was lost in the laundry. [S/he] just yelled and slammed the door and on the table.
01/27/2024 - Thought [s/he] got [his/her] 5:00 PM meds twice and it make [him/her] act out.
01/29/2024 - Had an outburst today before dinner. [s/he] was in [his/her] room folding [his/her] clean clothes and [s/he] noticed [s/he] was missing 1 mate to [his/her] TED stockings, so [s/he] threw a fit. [S/he] started to throw [his/her] clothing basket, slamming the closet door and room door, and yelling on and on, saying 'What should [s/he] do now.' [S/he] was very angry. [S/he] settled down a bit after a few mins (minutes) of me telling [him/her] it was in the dryer.
02/01/2024 - When I got here [Resident 3] was already mad about [his/her] towels. I went to get [his/her] towels out the bathroom and [s/he] started cursing at me and swing on me. [S/he] lost [his/her] balance and fell to the floor. I helped [him/her] off the floor and [s/he] still trying to fight and bite me.

Resident 3's individual service plan, dated 06/07/2023, documented:
"Behavior Patterns: Destructive/Abuse - Requires supervision and monitoring to help manage/redirect destructive/abusive behaviors. Maintain low level of abusive or destructive behaviors with supervision/intervention from staff."

On 04/19/2024 at 5:52 PM, Surveyor emailed Licensee A, Co-Owner B, Administration C, and Assistance Executive Director F. Surveyor asked Co-Owner B if s/he could explain how they came about speaking with [Resident 3] and then putting [Caregiver AA] into a situation where [Resident 3] was agitated, resulting in a staff-to-resident

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altercation. Surveyor asked Co-Owner B if s/he was aware of Resident 3's behaviors, his/her triggers, and how to de-escalate a situation. Administration C forwarded the following incident report written by Co-Owner B:
"[Resident 3] called out to me, asking if [s/he] could talk to me. ... [s/he] wanted to talk to [his/her] [Caregiver AA] about something but [s/he] wanted me to also be there to hear what happened. [Resident 3] seemed calm and soft-spoken. ... all [s/he] would say was that it had to do with [his/her] morning shower. ... I was able to coordinate [Caregiver AA] coming up to the [hone] to accommodate [Resident 3's] request ... As we entered [his/her] bedroom and closed the door behind us. [Resident 3] remained seated as [Caregiver AA] stood towards the bed end of the room with myself on the entry-door side of the room. Both [Caregiver AA] and I stood about 2 feet apart, directly in front of [Resident 3]. ... Everyone started the conversation with smiles and respect ... [S/he] felt that [Caregiver AA] was not being attentive enough to [him/her] during the showering and mentioned a few items. As [Resident 3] was telling [his/her] story, [s/he] became more and more excited and animated. ... It became clear that this meeting was growing out of control. I tried to summarize and conclude but to no avail. As [Caregiver AA] took my cue to apologize and depart, [Resident 3] surprisingly, (and unexpectantly ...since [s/he] is usually slow to get out of [his/her] chair) swiftly stood-up from [his/her] chair, reached 1 arm forward and struck [Caregiver AA] in [his/her] upper chest/arm area. [Caregiver AA] tried to move quickly towards me to head for the door which caused me to stumble, nearly falling to the floor as I instinctively reached forward to gain my balance, coming into light contact with [Caregiver AA] in the action. ... Incident Possible Action Steps to have a better

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M 426	Continued From page 54 outcome: [Co-Owner B] could have tried 3 times (as is typical in med-passing protocol) to try to get more information from [Resident 3] and [Caregiver AA] before deciding to bring them together; Positioning the meeting participants should have had either more physical distance positioned between them or be on opposite/opposing sides of a conference room table. ..."	M 426		
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 4 of the 4 residents who reside in the home, which would accommodate individual resident needs and preferences. Findings include: 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.	M 430		

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M 430	Continued From page 55 On 02/02/2024, the Department received a concern alleging activities are not provided to residents. 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 POA HH. POA HH stated, "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. Staff will focus on cleaning, instead of interacting with the residents. Why can't they do cleaning during the night shift?" POA HH stated s/he brings Resident 5 to the community room to do activities with him/her and will provide activities for other residents who are interested. On 02/26/2024, at approximately 10:20 AM, Surveyor interviewed POA Q. POA Q stated staff clean during day shifts instead of spending time with the residents. POA Q stated, "Why can't staff ask if [Resident 2] would like to play cards or something. If [s/he] says no, ask [him/her] five minutes later. [S/he] has a traumatic brain injury	M 430		

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and suffers from severe short-term memory loss. Ask [him/her] again, [s/he] will probably say yes, because [s/he] will have forgotten you already asked."

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."

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 HH and Resident 5 playing a game of Yahtzee in the community room, along with POA Q and Resident 2 playing cards in the community room. Surveyor

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M 430	Continued From page 57 asked Resident 2 if staff play cards with him/her. Resident 2 stated, "No." POA Q stated, "I have never seen a staff member play cards with [him/her]." On 03/06/2024, from approximately 12:30 PM to 4:00 PM, Resident 1 was left to sit in his/her room, facing his/her bed, with his/her tv to the left of him/her. Resident 1 had to try and turn his/her head to watch the tv. On 03/08/2024, at approximately 10:50 AM, Surveyor interviewed Caregiver V. Caregiver V stated, "They took [his/her] hours, [s/he] was supposed to do activities on Thursdays." On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver Z. Caregiver Z 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 G and previous Caregiver K. Caregiver G and Caregiver K explained that the individuals hired to oversee activities, were not aware of the different diagnoses that the residents had, so often 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 G and Caregiver K stated, "[Resident 5's] [POA HH] 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, while onsite for a previous survey, 03/06/2024, and 04/11/2024.	M 430		

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M 430	Continued From page 58 On 04/09/2024, Surveyor reviewed Resident 1's, Resident 2's, and Resident 3's individual service plan (ISP) which documented: Resident 1's ISP, dated 11/07/2023, documented: Leisure Time Activities - Leisure Time Independent - Independent with leisure time activities. Resident 2's ISP, dated 12/27/2023, documented: Leisure Time Activities - Leisure Time Independent - Independent with leisure time activities. Resident 3's ISP, dated 12/05/2023, documented: Leisure Time Activities - Leisure Time - Requires staff to offer activities/encouragement and monitor participation. 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 showed Surveyor the activity sheet that was now being hung up in the home. 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 438	88.07(2)(b) SERVICES DIRECTED TO GOALS Services shall be directed to the goal of assisting, teaching and supporting the resident to promote his or her health, well-being, self-esteem, independence and quality of life. The services shall include but are not limited to:	M 438		

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This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did not provide services specified in 2 of 2 resident Individual Service Plans (ISP).

Resident 2's and Resident 3's ISP identified s/he required daily exercises, which were not received.

Findings include:

On 04/09/2024, Surveyor reviewed Resident 2's and Resident 3's record.

Example 1: Resident 2

On 02/26/2024, at approximately 10:20 AM, Surveyor interviewed Resident 2's Power of Attorney (POA) Q. Surveyor asked POA Q if s/he had any concerns regarding Resident 2's cares. POA Q stated, "[Resident 2] is supposed to be walking 3x a day with a walker and I know that is not happening, because [s/he] just wants to be in [his/her] wheelchair. Staff are supposed to encourage [him/her]. [S/he] has short-term memory. If [s/he] says no, ask [him/her] five minutes later. Every time I arrive, [Resident 2] is in [his/her] wheelchair."

Resident 2's "6 Month Assessment," dated 06/06/2023, documented:
"Mobility and Transferring: Monitor that they are walking properly and comfortably. Give resident verbal prompting and encouragement as needed. Resident must use a walker. Remind resident to use a walker should [s/he] forget. [S/he] may forget and staff need to point where [his/her] room or bathroom is located if needed. Requires

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full assist and cues while mobile/walking. Resident uses wheelchair and does little to no walking."
"Physical Health - Therapeutic Exercises: Requires staff assistance to perform/complete exercise plan/activities. Maintain exercise plan/reach exercise goals with assistance from staff."

Resident 2's "6 Month Assessment," dated 12/27/2023, documented:
"Mobility and Transferring: Monitor that they are walking properly and comfortably. Give resident verbal prompting and encouragement as needed. Resident must use a walker. Remind resident to use a walker should [s/he] forget. [S/he] may forget and staff need to point where [his/her] room or bathroom is located if needed. Requires full assist and cues while mobile/walking. Resident uses wheelchair and does little to no walking."
"Physical Health - Therapeutic Exercises: Requires staff assistance to perform/complete exercise plan/activities. Maintain exercise plan/reach exercise goals with assistance from staff."

Resident 2's "Observation" notes, dated 01/01/2023 to 02/15/2024, documented:
10/17/2023 - Called [doctor's office] to request that the PT order be faxed. Needed to call Neurology. Will fax order to [provider].
Surveyor did not find documentation to show that the physical therapy order was received.

Resident 2's record did not contain any documentation regarding the assistance/completion of his/her daily walking.

Surveyor observed Resident 2 on 02/13/2024,

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M 438	Continued From page 61 02/14/2024, 03/06/2024, and 04/11/2024. Resident 2 was always in his/her wheelchair. 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 if there was additional documentation to show that staff were assisting Resident 3 with his/her daily exercises. Licensee A stated Surveyor had received all requested documentation. Co-Owner B stated exercises were now a part of the daily activities for all residents. Example 2: Resident 3 On 02/23/2024, at approximately 10:55 AM, Surveyor interviewed Resident 3's POA FF. POA FF stated, "[Resident 3] is supposed to be receiving PT (exercises). I am not sure staff are assisting [him/her] or if they are even trained to assist [him/her]. When [s/he] moved in [s/he] was supposed to practice walking with [his/her] walker, so [s/he] would keep that strength and ability. I don't know how that was handled because [s/he] is wheelchair bound now." Resident 3's "6 Month Assessment: ISP," dated 06/07/2023, documented: "Mobility & Transferring: Monitor that they are walking properly and comfortably. Give resident verbal prompting and encouragement as needed. "Physical Health - Therapeutic Exercises: Requires staff assistance to perform/complete exercise plan/activities. Maintain exercise plan/reach exercise goals with assistance from staff." Resident 3's "6 Month Assessment: ISP," dated 12/05/2023, documented:	M 438		

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M 438	Continued From page 62 "Mobility & Transferring: Monitor that they are walking properly and comfortably. Give resident verbal prompting and encouragement as needed. Remind to use walker." "Physical Health - Therapeutic Exercises: Requires staff assistance to perform/complete exercise plan/activities. Maintain exercise plan/reach exercise goals with assistance from staff." Resident 3's progress notes, dated 06/01/2023 to 02/25/2024, documented: "06/19/2023 - Did [his/her] daily exercise." "08/30/2023 - Resident did exercises today with activity director." "11/11/2023 - Exercise was completed." "02/25/2024 - Said [s/he] missed [his/her] exercise this morning. ... at 6:45 PM, [Resident 3] did [his/her] daily exercise." 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 if there was additional documentation to show that staff were assisting Resident 3 with his/her daily exercises. Licensee A stated Surveyor had received all requested documentation. Co-Owner B stated exercises were now a part of the daily activities for all residents.	M 438		
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:	M 444		

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M 444	Continued From page 63 Based on record review and interview, the provider did not provide or arrange for transportation and/or accompany 1 of 1 resident (Resident 2) to their medical appointments. Findings include: 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. On 02/23/2024, at approximately 12:25 PM, Surveyor interviewed Resident 2's temporary managed care organization (MCO) Care Manager (CM) II. CM II stated, "The concern that [Resident 2's] [Power of Attorney (POA) Q] had was that the provider was not providing transportation to [Resident 2's] medical appointments. The provider was relying on the family to do it. This was discussed with the provider and that they are responsible for transportation per their MCO contract." On 02/23/2024, Surveyor requested and reviewed Resident 2's MCO documentation, dated 06/2022 through 01/2024, from CM S, which documented: "Concern for overall safety when alone or in community due to decision making skills: Support provided for safety concern(s): Due to cognitive impairment member should be with AFH (adult family home) staff or family while out in community."	M 444		

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On 02/26/2024, at approximately 12:30 PM, Surveyor interviewed Resident 2's MCO CM S. CM S stated there had been concerns regarding transportation and accompaniment to Resident 2's medical appointments.

On 02/26/2024, at approximately 10:20 AM, Surveyor interviewed Resident 2's POA Q. POA Q stated, "[The provider] would call me and say they don't have anybody to take [him/her] to [his/her] scheduled medical appointment. One time, they sent [him/her] alone to a dentist appointment. I get a phone call from the dentist's office voicing concerns that staff isn't with [him/her]. The dentist canceled the appointment. The provider should know better. [S/he] should never be sent to a medical appointment alone. Then they will have [Maintenance DD] assist them with driving [Resident 2] to [his/her] appointments. [Maintenance DD] does not like driving to the hospital in Milwaukee, so luckily my [grandson/daughter] was visiting, and [s/he] transported [Resident 2] to all of [his/her] medical appointments. Appointments that got rescheduled due to staff not following procedures and feeding [Resident 2] prior to [his/her] appointment. I am [age] years old, I can't keep doing this." POA Q continued to explain, "There was a situation where [Resident 2] had a physical therapy (PT) appointment. [Co-Owner B] said [s/he] would drive [him/her] there and I would meet them at the appointment. [Resident 7], who is allowed to roam all of the homes, decides [s/he] needs to go on a car ride and [Resident 7] must sit in the front otherwise [s/he] will be upset. So, [Resident 2] gets into the back of the car. [Co-Owner B] is talking about how they are going to be late to the appointment. [Resident 2] becomes so upset, because [s/he] is never late to anything. That is just [his/her] personality. When

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[s/he] finally got to PT, [s/he] wouldn't participate, because [s/he] was so upset. It was a totally wasted appointment. All because [Co-Owner B] did not know how to control [Resident 7] and didn't understand making it obvious they were going to be late would be a trigger for [Resident 2]." POA Q explained another situation. POA Q stated, "[Resident 2] had a fall in 06/2022 where [s/he] broke [his/her] hip. Supposedly, fell out of bed. They didn't realize [s/he] had a broken hip. They sent [him/her] to the doctor finally, alone, and [s/he] couldn't answer any of the questions." POA Q stated, "[Co-Owner B] has never taken Resident 2 to a medical appointment."
On 03/08/2024, at approximately 10:45 AM, Surveyor interviewed previous Caregiver V. Caregiver V stated, "[Resident 2] told [him/her] that [Co-Owner B] scared [him/her] by driving the truck too fast. It really upset [him/her] because [s/he] has already been in a car accident." Surveyor asked if Resident 2 had missed any medical appointments due to transportation concerns. Caregiver V stated, "Yes, [s/he] has missed a medical appointment. They always rely on [POA Q] to take [him/her] to [his/her] appointments. They are supposed to have a third person on staff so they can go to the appointments, but they don't. They can't keep staff or they are firing them, so there is never enough people. We are always short staffed."

On 03/08/2024, Surveyor reviewed Resident 2's record.

Resident 2 was admitted to the home, 04/22/2021, with diagnoses including traumatic brain injury due to a motorcycle accident, abnormality of gait, and seizure disorder.

Resident 2's "6 Month Assessment," dated

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M 444	Continued From page 66 12/07/2023, documented: "Destructive/Abusive: Requires supervision and monitoring to help manage/redirect destructive/abusive behaviors. [Resident 2] yells and uses foul language at times." "Attitude: [Resident 2] has bad temper problem. [S/he] sometimes would yell out profanity when being reminded to toilet. [S/he] usually is very polite and says "Thank You" for anything that caregiver helps [him/her] with." "Transportation - Independent: Maintain independence and receive transportation to desired locations." The assessment did not identify that Resident 2 had to be accompanied to all medical appointments. On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver Z. Caregiver Z stated Resident 2 had missed medical appointments. 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 they have communicated with POA Q to determine what appointments s/he would like a staff member present. 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		

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M 448	Continued From page 67	M 448		
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 ensure that 1 of 1 resident was monitored and that observed changes in his/her health were documented. Resident 1's edema was not monitored by staff. Findings include: On 02/02/2024, the Department received a concern that residents who had swelling of their legs were not provided proper cares. On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Surveyor asked Caregiver I if s/he had concerns regarding Resident 1's legs. Caregiver I stated, "[His/Her] legs are to be elevated and staff will just let them rest on [his/her] wheelchair. They are not elevated, [s/he] is in a sitting position with the legs hanging on the footrests. There is nothing in [his/her] ISP (individual service plan) about elevating [his/her] legs. If I said anything to [Co-Owner B], [s/he] would say, 'It is being taken care of.' If anybody looked at [his/her] legs, you could see how swollen they were. The back of [his/her] left leg had skin breakdown, it looked like a serious red rash. Why would staff not seek guidance on how to address this?" Caregiver I	M 448		

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forwarded Surveyor a picture of Resident 1's leg for review.

On 02/25/2024, at approximately 9:45 AM, Surveyor interviewed previous Caregiver J. Surveyor asked if Caregiver J was aware that Resident 1's legs were to be elevated. Caregiver J stated, "I never seen [his/her] legs elevated. [His/her] legs are always swollen."

On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Surveyor asked Manager N if s/he had concerns regarding Resident 1's legs. Manager N stated, "[S/He] sleeps really weird. [S/He] sleeps half in [his/her] bed with [his/her] legs resting on the wheelchair; it made me nervous. [S/He] should have [his/her] legs elevated which is not happening. I suggested a reclining chair to assist with elevating [his/her] legs." Surveyor asked how s/he knew that Resident 1's legs were to be elevated. Manager N stated based on his/her training, when a resident experienced edema, their legs were to be elevated.

On 03/02/2024, at approximately 9:20 AM, Surveyor interviewed Caregiver L. Surveyor asked if Caregiver L was aware that Resident 1's legs were to be elevated. Caregiver L stated, "[His/Her] legs are to be elevated. I can't say all staff do that."

On 03/02/2024, at approximately 11:10 AM, Surveyor interviewed Caregiver U. Surveyor asked if Caregiver U was aware that Resident 1's legs were to be elevated. Caregiver U stated, "[His/Her] legs get really swollen. I try to elevate them during [his/her] sleep but [s/he] sleeps half in [his/her] bed and half on [his/her] wheelchair. I haven't read anything about how [his/her] legs

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should be elevated."

On 03/06/2024, at approximately 3:35 PM, while Surveyor was observing Resident 1, Licensee A walked into his/her room. Licensee A stated, "[Resident 1] needs to sit in living room so [his/her] legs could be elevated in recliner." Licensee A left to go find a staff member. Surveyor observed Resident 1 from 12:30 PM to 4:00 PM, and s/he sat in his/her wheelchair, in front of his/her bed, the entire time. His/her legs were not elevated. Surveyor observed what appeared to be a leg compression device laying in the corner, between the bed and the wall.

On 03/08/2024, at approximately 10:45 AM, Surveyor interviewed previous Caregiver V. Surveyor asked if Caregiver V was aware that Resident 1's legs were to be elevated. Caregiver V stated, "[S/he] had been told that [his/her] legs are to be elevated but [s/he] doesn't like to do it. [His/her] legs are always swollen."

On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver Z. Surveyor asked if Caregiver Z was aware that Resident 1's legs were to be elevated. Caregiver Z stated, "[His/Her] legs were to be elevated. Every time I came onto my shift, they weren't. Staff would tell me, [s/he] doesn't want to. They don't know how to redirect [Resident 1]. I could go in there and say, 'Hey [Resident 1], lets go sit in the tv room, so you can sit in the recliner and elevate that leg.' [S/he] would be like 'okay.' [S/he] is just the sweetest person. [S/he] suffers from extreme edema, we need to make sure [his/her] legs are elevated."

On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver G and

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previous Caregiver K. Surveyor asked if they were aware that Resident 1's legs were to be elevated. Caregiver G and Caregiver K stated, "[S/he] needed to wear stockings and make sure [his/her] legs were elevated; [s/he] dealt with edema." Surveyor asked if Resident 1's legs were elevated on a consistent basis to assist with his/her edema. Caregiver G and Caregiver K stated, "Staff often did not elevate them; there was an influx of staff and staff probably were not trained properly on it." Surveyor asked how Caregiver G and Caregiver K knew that Resident 1's legs were to be elevated. Caregiver G stated, "Based on my previous training."

On 04/09/2024, Surveyor reviewed Resident 1's record.

Resident 1 moved into the home, 02/14/2023, with diagnoses including: cellulitis of left lower limb, muscle weakness, symptomatic epilepsy, idiopathic peripheral autonomic neuropathy (nerve damage), and traumatic brain injury.

Resident 1's "Initial Assessment," dated 02/14/2023, documented:
"Physical Disabilities: Resident's left leg does not bend. Wound care nurse comes to assist."
Resident 1's "6 Month Assessment," dated 11/07/2023, documented:
"Chronic Illnesses: Has chronic illness(es) that require proper treatment and management. Boths legs are swollen and needs to put on compression socks in the morning. Remove them at night and handwash them."
"Physical Disabilities: Resident's left leg does not bend. Wound care nurse comes to assist."
Surveyor noted this assessment should have been completed in 08/2023, since the assessment is used as the resident's ISP.

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Resident 1's "ISP," dated 02/13/2024, documented:
"Chronic Illnesses: Has chronic illness(es) that require proper treatment and management. Boths legs are swollen and needs to put on compression socks in the morning. Remove them at night and handwash them."
"Physical Disabilities: Resident's left leg does not bend. Wound care nurse comes to assist."

Resident 1's "Observation" notes, dated 02/14/2023 to 03/06/2024, documented:
01/14/2024 - Resident's legs are swollen, especially the right leg. Resident can't get [his/her] legs up in bed without help. Resident nearly fell to floor from bed because [s/he] was having a harder time lifting up [his/her] legs to wheelchair."
01/16/2024 - Resident stated [s/he] didn't feel well after dinner time and went to bed.
01/19/2024 - Observed resident huffing and puffing (out of breath) while pushing [him/herself] in [his/her] wheelchair throughout shift,
02/16/2024 - Gave [him/her] [his/her] hourly leg compressor treatment.
Surveyor noted this entry occurred after the start of the survey process.
Surveyor noted in 2023 there were no entries regarding concerns with Resident 1's edema or what protocol staff had completed regarding his/her edema. The only comments that were recorded is when nursing staff came in and changed out Resident 1's leg wraps.
Surveyor noted the entries for 2024 did not document that Resident 1 refused to wear prescribed leg wraps.

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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M 448	Continued From page 72 and Assistant Executive Director (AED) F. AED F stated s/he had increased his/her documenting in resident observation notes. Licensee A stated staff should be assisting Resident 1 with elevating his/her leg. "Symptoms of edema include: Swelling or puffiness of the tissue right under the skin, especially in legs or arms. Stretched or shiny skin. Skin that holds a dimple, also known as pitting, after it's been pressed for a few seconds. Swelling of the belly, also called the abdomen, so that it's bigger than usual. Feeling of leg heaviness. Make an appointment to see a health care provider for swelling, stretched or shiny skin, or skin that holds a dimple after being pressed. See a provider right away for: Shortness of breath. Irregular heartbeat. Chest pain. These can be signs of fluid buildup in the lungs, also known as pulmonary edema. It can be life-threatening and needs quick treatment. The following may help decrease edema and keep it from coming back. Talk to your health care provider about which of these might help you. Use pressure. If edema affects an arm or leg, wearing compression stockings, sleeves or gloves might help. These garments keep pressure on the limbs to prevent fluid from building up. Usually worn after the swelling goes down, they help prevent more swelling. Move. Moving and using the muscles in the part of the body that's swollen, especially the legs, might help move fluid back toward the heart. A health care provider can talk about exercises that might reduce swelling. Raise. Hold the swollen part of the body above the level of the heart several times a day. Sometimes, raising the swollen area during sleep can be helpful.	M 448		

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M 448	Continued From page 73 Massage. Stroking the affected area toward the heart using firm, but not painful, pressure might help move fluid out of that area. Protect. Keep the swollen area clean and free from injury. Use lotion or cream. Dry, cracked skin is more open to scrapes, cuts and infection. Always wear socks or shoes on the feet if that's where the swelling usually is. Reduce salt. A health care provider can talk about limiting salt. Salt can increase fluid buildup and worsen edema. (Source: Mayo Clinic website, Edema, July 28,2023, https://www.mayoclinic.org/diseases-conditions/edema/symptoms-causes (retrieval date: 04/22/2024).)	M 448		
M 450	88.07(2)(b)6 NOTIFICATION OF CHANGES Notifying the placing agency, if any, the guardian, if any, of any significant changes in the resident's medical condition, including any life-threatening, disabling or serious illness, any illness lasting more than 3 days, an injury sustained by the resident, medical treatment needed by the resident or the resident's absence from the home for more than 24 hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident's (Resident 2) managed care organization (MCO)	M 450		

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care manager (CM) was informed when Resident 2 required medical treatment.

Resident 2 had sustained an unwitnessed fall which resulted in hospitalization. Resident 2's MCO CM S was not informed until 4 days after hospitalization.

Findings include:

On 02/23/2024, Surveyor requested and reviewed Resident 2's MCO records from CM S.

Resident 2's MCO records documented:
"Date of fall: 05/29/2022, Date CCI notified of fall: 06/14/2022, Injury sustained as a result of the fall; no injury, Location of fall: Bedroom, and Description of fall: Unwitnessed; member presented free of injury. Falls risk agreement not in place."
"Date of fall: 06/10/2022, Date CCI notified of fall: 06/14/2022, Injury sustained as a result of the fall; required ER (emergency room) visit with hospital stay and surgery."
"Care Management: Date of Admission - 06/11/2022. Reason for Admission - Post fall-broken hip. Date of Discharge: 06/18/2022."

On 02/26/2024, at approximately 10:20 AM, Surveyor interviewed Resident 2's Power of Attorney (POA) Q. POA Q stated Resident 2 had fallen out of his/her bed and broke his/her hip. POA Q stated, "[Licensee A] and [Co-Owner B] could not tell me how it happened or even when it happened."

On 02/26/2024, at approximately 12:30 PM, Surveyor interviewed CM S. CM S stated, "We were not informed when [Resident 2] broke [his/her] hip. This has been an ongoing problem.

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When we ask for an incident report regarding an incident or a fall, we are unable to get one. We found out about [Resident 2's] broken hip when [his/her] POA contacted us."

On 02/28/2024, Surveyor reviewed Resident 2's record.

Resident 2 was admitted to the home, 04/22/2021, with diagnoses including traumatic brain injury, abnormality of gait and seizure disorder.

Resident 2's Incident Reports for 2022 included:
"06/07/2022 - Resident yelled out for someone to help him. When staff entered room resident was laying on the floor sideways with [his/her] left hip on floor. Resident was not in any pain but needed assistance up. [S/he] was able to do the full ROM (range of motion) except [his/her] right leg. [S/he] said that is frozen."
"12/28/2022 - [Resident 2] was trying to get ice from the refrigerator. [His/Her] walker's break [sic: brake] was not locked tight. [Resident 2] lost [his/her] balance and fell backwards."
Surveyor noted there was no incident report for a fall on 05/29/2022 or 06/10/2022.

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. 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 and when an incident report should be created. AED F stated s/he would be following up with point-of-contacts for residents to ensure all resident representatives have been contacted.

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M 450	Continued From page 76 Cross Reference: M0580 DHS 88.10(3)(p) Prompt and Adequate Treatment	M 450		
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 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 01/31/2024, at approximately 11:10 AM, Surveyor toured the home. Surveyor noted there was a limited amount of food readily available in the refrigerator, freezer, and cabinets. 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.	M 470		

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M 470	Continued From page 77 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 X. Caregiver X 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, 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."	M 470		

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M 470	Continued From page 78 On 02/23/2024, at approximately 10:55 AM, Surveyor interviewed Resident 1's Power of Attorney (POA) D. POA D stated, "[Resident 1] deals with edema. [S/he] really should avoid salty meals. I don't think that is taken into consideration because [his/her] edema keeps getting worse." On 02/24/2024, at approximately 1:30 PM, Surveyor interviewed previous Caregiver I. Caregiver I stated, "Food was scarce. Most caregivers would bring food in from their home for their shift, so residents have something decent to eat and/or something they knew how to cook. When food is brought, half the time it is not proper for the residents due to allergies, or the food is difficult to swallow." On 02/26/2024, at approximately 10:20 AM, Surveyor interviewed Resident 2's POA Q. POA Q stated, "I have taken meals in for all the residents so they can enjoy some nice homecooked meals. The staff do not always know how to cook and I wonder about some of the meals that are served." On 03/01/2024, at approximately 2:15 PM, Surveyor interviewed previous Manager N. Manager N stated, "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	M 470		

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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 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 Z. Caregiver S stated, "At times food was non-existent. Employees have been known to get food for the residents. [Manager F] would

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M 470	Continued From page 80 bring food in from the food pantry." On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver G and Caregiver K. Caregiver G stated, "Staff would cook what they wanted or what they knew how to; 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 G stated that staff would eat the food which caused behaviors in residents when they requested seconds, and the food was gone. Caregiver G and Caregiver K 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 G and Caregiver K 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. Surveyor asked if the concern outlined were factual prior to the start of the survey process. Licensee A stated there had been concerns with staff not following the menu which caused concerns. Surveyor asked if food had been brought in from the food pantry. Surveyor did not receive a response.	M 470		
M 474	88.07(4)(c) FOOD PREPARED AND STORED SANITARY WAY	M 474		

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M 474	Continued From page 81 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 did not store food under sanitary conditions. Surveyor found food items in the refrigerator and pantry that were not properly sealed to avoid contamination. 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 03/06/2024, at approximately 1:00 PM, Surveyor toured the kitchen and observed the following: Refrigerator: -9 ounce open container of processed honey roasted turkey sandwich slices with a handwritten open date of 01/08/2024. -(2) 9 ounce open container of processed black forest ham sandwich slices with a handwritten open date of 02/22/2024. -.56 pound of pickle pimento loaf with a purchase date of 02/17/2024. -A clear plastic bag of peaches with a handwritten open date of 02/22/2024. -A clear plastic bag of blueberries with a	M 474		

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handwritten open date of 02/21/2024.
-A clear plastic bag of mixed berries with a handwritten open date of 02/20/2024.
-A clear bag of applewood flavored bacon that was not dated.

Pantry:
-20 ounce open box of flapjack and waffle mix that was not sealed.
-An opened taco dinner kit that contained 12 taco shells that was not sealed.
-16 ounce open box of thin spaghetti that was not sealed.
-10 pound box of basmati rice sitting directly on the floor.
-(2) bags of red potatoes sitting directly on the floor.
-(1) bag of russet potatoes sitting directly on the floor.
-14.5 ounce box of cinnamon oatmeal square cereal that was not sealed and had a 'best before' date of 11/29/2023.
-2 pound opened bag of organic cereal that was not sealed and had a handwritten open date of 01/03/2023.
-32 ounce opened bag of brown sugar that was not sealed.

Surveyor noted the ice machine on the refrigerator had a significant amount of what appeared to be hard water build up.

"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

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M 474	Continued From page 83 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 (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 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 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.	M 548		

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M 548	Continued From page 84 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents were treated with courtesy, respect and full recognition of the resident's dignity and individuality. Resident 2 required to purchase his/her own chair and bed alarm when s/he was under a managed care organization (MCO). The MCO stated the provider was responsible for the chair and bed alarm purchases. Licensee A and Co-Owner B charged Resident 3 a $2500 'Non-refundable Entrance Reservation Fee' prior to him/her moving in, to secure his/her room. Resident 3's Power of Attorney (POA) FF had to front the funds as Resident 3 was a Medicaid recipient. The MCO stated the provider should not request a room hold fee. Findings include: Example 1: Resident 2 On 02/26/2024, at approximately 10:20 AM, Surveyor interviewed Resident 2's power of attorney (POA) Q. POA Q stated s/he had to purchase the chair and bed alarm because Resident 2 was determined to be a fall risk. POA Q stated, "They [Licensee A] and [Co-Owner B] kept talking about how [Resident 2] needed chair and bed alarms to alert staff as to when [s/he] was trying to get up. They wouldn't purchase them. So, I finally did it, so [Resident 2] would be safe. I didn't know that purchase should have been made between the MCO (managed care organization) and [Licensee A] and [Co-Owner B]. I wonder if [Licensee A] and [Co-Owner B] even talked to [his/her] care manager."	M 548		

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M 548	Continued From page 85 On 02/26/2024, at approximately 12:30 PM, Surveyor interviewed Resident 2's MCO CM S. CM S stated a resident should not have to purchase the chair and bed alarms when they are supported by the MCO. CM S stated s/he was working with Licensee A and Co-Owner B about reimbursing POA Q. CM S stated, "I informed [POA Q] that if [Licensee A] or [Co-Owner B] approach you about buying items for Resident 3, besides personal items, please contact me first, because the POA is not responsible for purchasing these types of items." Resident 2's observation notes, dated 08/01/2023 to 02/15/2024, documented: 01/30/2024 - During round check [Resident 2] was in [his/her] recliner but [his/her] chair alarm was not under [him/her], it is required that [s/he] has it at all times during transfers." 02/05/2024 - [Resident 2] has 2 alarms [his/her] [mom/father] bought new batteries. 1 stays in [his/her] bed and the other stays in [his/her] chair. On 03/06/2024, at approximately 1:30 PM, Surveyor interviewed Licensee A. Licensee A stated POA Q had purchased Resident 2's bed and chair alarm because s/he was a fall risk and Licensee A thought it would be helpful. Example 2: Resident 3 On 04/10/2024, at approximately 3:25 PM, Surveyor interviewed Resident 3's POA FF. POA FF asked Surveyor if it was appropriate for a provider to charge an individual a room hold fee when they are on Medicaid. POA FF stated, "I paid the $2500 fee because [Co-Owner B] made it sound like they would not hold the room for [Resident 3] while they gained approval from	M 548		

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[his/her] MCO provider. [Resident 3] didn't have that kind of money, so I paid it, and I don't have that kind of money." POA FF forwarded Surveyor a copy of his/her canceled check (08/16/2022) and his/her receipt for the fee from the provider.

On 04/16/2024 at 7:32 AM, Surveyor emailed Resident 3's MCO Care Manager (CM) GG. Surveyor asked for guidance regarding potential resident's who are covered by an MCO and security deposits to hold their room for a potential placement. CM GG stated, "I talked to the provider and the guardians to warn them not to pay this fee. At first, after I told the guardian not to pay it, they said they would not. But then I found out later that they did pay it. When I talked to the provider about it, they acted like they did not need to pay it but then there wouldn't be a guarantee that [Resident 3] would keep [his/her] spot."

On 04/17/2024, Surveyor reviewed Resident 3's record.

Resident 3 moved into the home on 11/17/2022.

Resident 3's "Admission Agreement," dated 11/17/2022, documented:
"Fees: A refundable security deposit of one month rent is required. The Basic Services Rate, as of the date of this Agreement is $ per agreed rate of [MCO] per day. This rate has been set by agreement between the [provider] and the resident's representative."

On 04/17/2024 at 8:35 AM, Surveyor emailed Licensee A and Administration C. Surveyor requested guidance regarding MCO recipients being required to pay a security deposit prior to placement.

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M 548	Continued From page 87 On 04/17/2024 at 10:11 AM, Administration C stated, "[MCO] does not pay a security deposit. [Resident 3] did not pay a security deposit, so no refund was given." On 04/17/2024 at 12:30 PM, Surveyor stated it had been reported that Resident 3 was required to pay a $2500 fee prior to placement. On 04/17/2024 at 12:51 PM, Administration C stated, "This is not a security deposit, it is a Non-refundable Entrance Reservation Fee for [provider] to hold a room for the resident. When document is read, it is fully explained, prior to signing." Administration C stated s/he would discuss the concern with Licensee A and Co-Owner B.	M 548		
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	M 552		

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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 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

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M 552	Continued From page 89 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." 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 560	88.10(3)(g) Clothing and Possessions	M 560		

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M 560	Continued From page 90 Clothing and possessions. To retain and use personal clothing and effects and to retain, as space permits, other personal possessions in a reasonable secure manner. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 1resident had the right to retain and use personal clothing. Resident 2's walker was placed in storage by staff without permission. Findings include: On 02/26/2024, at approximately 10:20 AM, Surveyor interviewed Resident 2's Power of Attorney (POA) Q. POA Q stated Resident 2's walker disappeared. POA Q stated, "It was brand new with a blue seat. Management says they do not know what happened to it. They found some old one for [him/her] to use. How does a walker just disappear, there are only 4 residents in this home." POA Q explained, "Management really does not believe when a family member expresses concerns that an item is missing. For instance, "[Resident 2's] electric razor disappeared. I informed [Co-Owner B] about it and stated that I suspect [Resident 7] had taken it. [Co-Owner B] denied it. Another family member informed me that they saw it in [Resident 7's] pants pocket. I informed [Co-Owner B] who then retrieved it and really did not have an explanation." (Resident 7 resides in an adjoining home.) On 02/28/2024, Surveyor reviewed Resident 2's record.	M 560		

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Resident 2 was admitted, 04/22/2021, with diagnoses including peripheral vascular disease, arthritis, abnormality of gait, muscle weakness, traumatic brain injury and seizure disorder.

Resident 2's "6 Month Assessment," dated 12/27/2023, documented:
"Mobility and Transferring: Resident must use a walker. Remind resident to use a walker should [s/he] forget."

Resident 2's "Observation" notes, dated 01/01/2022 to 02/13/2024, did not document a concern regarding Resident 2's missing walker.

Resident 2's record did not contain an incident report regarding his/her missing walker.

On 03/01/2024, at approximately 11:50 AM, Surveyor interviewed previous Caregiver M. Caregiver M stated, "[Resident 2's] [mother/father] told me about the missing walker. I have never seen [Resident 2] use a walker. [S/he] is a standby assist."

On 03/02/2024, at approximately 11:10 AM, Surveyor interviewed Caregiver U. Surveyor asked if Resident 2 had a new walker that had been misplaced. Caregiver U stated, "The walker disappeared. I do not know what happened to it."

On 03/06/2024, at approximately 2:25 PM, Surveyor observed a silver-colored walker in Resident 2's room.

On 04/09/2024, at approximately 12:40 PM, Surveyor interviewed previous Caregiver Z. Caregiver Z stated, "[S/He] had a blue walker. We used it for [him/her] to get out of bed."

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M 560	Continued From page 92 On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver G and previous Caregiver K. Caregiver K stated, "[Resident 2] had a blue walker. The walker was out in the garage on the shelf, to the right of the exercise machine on the top shelf. I was told to put it away by [Licensee A], because staff needed to assist [Resident 2] with walking and staff wouldn't, so I had to put it away unless I was working." Caregiver K left employment in 10/2023. 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, "Yeah, it is stored on a shelf in the storage area. We could get it out." Surveyor asked why Resident 2 did not have access to his/her walker. Surveyor did not receive a response.	M 560		
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 observation, record review and interview, the provider did not keep 2 of 2 resident free from misappropriation of property. Resident 2's and Resident 3's petty cash was misappropriated. Finding include:	M 572		

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

On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver G and previous Caregiver K. Caregiver G stated that s/he oversaw the resident's petty cash. Caregiver G 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] started questioning themselves about 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 G stated that Co-Owner B and Licensee A were not going to report the missing money to law enforcement. Caregiver G 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 2] $15.00; Victim [Resident 3] $96.00"
"Upon my arrival, I met with [Caregiver G and Caregiver K]. ... [Caregiver G] 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]

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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 G] fill out a written statement, and a Restitution form for each of the victims. [S/he] felt that [Licensee A and Co-Owner B] may be reimbursing the residents. ... [Caregiver G] 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 G] stated ... the owners were reluctant to have this reported." "07/22/2023 - I spoke to [Caregiver G]. [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 04/10/2024, at approximately 3:25 PM, Surveyor interviewed Resident 3's POA FF. POA FF stated the provider did not reimburse Resident 3 after the theft of his/her petty cash. POA FF stated, "This has happened twice. I would email [Licensee A] and [Co-Owner B] and I did not even get a response." POA FF forwarded Surveyor the email correspondence which documented: 06/29/2023 POA FF emailed Licensee A and Co-Owner B: "When we got there yesterday the [sheriff department] was at the building. [Resident 3] talked to the deputy, as the deputy requested to talk to [him/her] and was informed that [Resident 3's] spending money of $100.00 was stolen while [Caregiver G] and [Caregiver K] were on vacation and that they would be investigating the theft. I just wanted to let you know that earlier in the spring [Resident 3] had

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M 572	Continued From page 95 $70.00 stolen from [his/her] room and at that time we turned [his/her] spending money over to [Caregiver G] to keep track of it and keep it locked up with the other clients money which was working our [sic: out] very well." 07/26/2023 POA FF emailed Co-Owner B: "Hi [Co-Owner B] just wanted to check back with you if you had talked to the police about the theft of money while [Caregiver G] and [Caregiver K] were on vacation. Also, will [Resident 3] be getting [his/her] $100 back from [home] since the money was in your care when it was stolen? Please let us know when you get a chance." 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. Surveyor observed while onsite 02/13/2024, 02/14/2024, 03/06/2024, and 04/11/2024 that the door to the office area was not locked. Surveyor was able to walk directly into the office. Cross Reference: M0610 DHS 88.11(1) Reporting of Abuse and Neglect	M 572		
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 did not receive prompt and adequate	M 580		

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treatment and services appropriate to his/her needs.

Resident 2 did not receive scheduled treatment due to staff not following pre-operative requirements.

Findings include:

On 02/02/2024, the Department received a concern that alleged a resident's surgery had been delayed due to staff error.

On 02/04/2024 at 12:01 PM, Surveyor emailed Licensee A and Administration C and requested documentation related to a resident who was scheduled for surgery in 09/2023 that was delayed. Surveyor received Resident 2's records.

Resident 2 moved into the home, 04/22/2021, with diagnoses including peripheral vascular disease (circulation disorder), traumatic brain injury, and seizure disorder.

Resident 2's "Observation" notes documented: "09/23/2023 - Resident had surgery today and everything went well."

Resident 2's medical documentation stated: Resident 2 underwent revision of right frontal VPS (ventriculoperitoneal shunt - removes excess cerebrospinal fluid) on 09/23/2023.

On 02/13/2024, at approximately 3:50 PM, Surveyor interviewed Lead Caregiver P. Lead Caregiver P stated, "[Resident 2] was scheduled for surgery to have a shunt (hollow tube) placed in [his/her] brain to drain fluid build-up. There was documentation hanging up reminding staff not to feed [Resident 2] breakfast that day."

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M 580	Continued From page 97 Resident 2's original appointment was 09/22/2023 and was rescheduled to 09/23/2023. On 02/14/2024, at approximately 11:20 AM, Surveyor interviewed Caregiver F. Caregiver F stated, "Yes, there were notes everywhere and staff were not paying attention. [Resident 2's] [Power of Attorney (POA) Q] was taking [Resident 2] to the doctor for [his/her] procedure. The doctors asked if [s/he] had eaten. [Resident 2] said yes and the procedure had to be delayed. The staff member (previous Caregiver BB) was questioned and [s/he] stated [s/he] had only fed [him/her] a little bit. [S/he] just wasn't paying attention." On 02/26/2024, at approximately 10:20 AM, Surveyor interviewed POA Q. POA Q stated, "I went to pick him up at noon for the surgery to have [his/her] shunt replaced to drain the fluid off [his/her] brain. We arrived at the facility, myself and my [grandson/daughter] and [s/he] was eating lunch and I was like [s/he] isn't supposed to eat; [s/he] has surgery. [Caregiver BB] was like 'oh that is right, sorry, [s/he] only ate 1/2 a hotdog and 3 onion rings.' I still took [him/her] to the appointment. The surgeon asked if [Resident 2] had eaten anything. Honestly, I didn't want to say anything, because [s/he] really needed the surgery but we informed the surgeon of what happened. The surgery was canceled. The surgeon was very angry with us. Then I find out, if they had performed the surgery, [s/he] could have aspirated and died, due to eating prior to the surgery. If I had not seen [Resident 2] eating, I really wonder if staff would have informed me." POA Q stated, "I had to ask my [granddaughter/son] to transport [Resident 2] on both days because [Licensee A] and [Co-Owner B] did not have anybody available to take	M 580		

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M 580	Continued From page 98 [Resident 2] to [his/her] appointments." 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, Co-Owner B, Administration C, and Assistant Executive Director F discussed the important of staff being trained appropriately and being held accountable. Cross Reference: M0444 DHS 88.07(2)(b)3. Transportation to Medical	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 immediately contact the licensing agency when they had reasonable cause to suspect that residents had been abused for 1 of 1 incident.

Resident 2's and Resident 3's petty cash was misappropriated.

Findings Include:

On 04/09/2024, at approximately 3:00 PM, Surveyor interviewed previous Caregiver G and previous Caregiver K. Caregiver G stated that s/he oversaw the resident's petty cash. Caregiver G 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 2] $15.00; Victim [Resident 3] $96.00"
"Upon my arrival, I met with [Caregiver G and Caregiver K]. ... [Caregiver G] stated ... the owners were reluctant to have this reported."
"07/22/2023 - I spoke to [Caregiver G]. [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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018172	A. BUILDING: _____ B. WING _____	C 04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTES PLACE 2	1515 B 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 100 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, 08/27/2020. Cross Reference: M0572 DHS 88.10(3)(m) Freedom From Abuse	Z 055		