STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013384	A. BUILDING: _____ B. WING _____	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE WHITEWATER MEMORY CARE	945 E CHICAGO ST WHITEWATER, WI 53190

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 05/07/2024, Surveyor conducted a standard survey at Our House Whitewater Memory Care. Four deficiencies were identified. Census: 17	N 000		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a caregiver background check was completed for each staff member at the time of hire for 2 of 2 caregivers reviewed. Background checks were not completed for Caregiver D and Caregiver G at time of hire. Findings include: On 05/07/2024, Surveyor reviewed Caregiver D's	N 219		

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

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N 219	Continued From page 1 and Caregiver G's employee records. Example 1 Caregiver D Caregiver D was hired 07/24/2023. His/her record contained background checks dated 12/03/2021 and 02/05/2024. Example 2 Caregiver G Caregiver G was hired 11/14/2022. His/her record contained a background check dated 02/06/2024. On 05/07/2024 at 12:54 PM, Surveyor interviewed Director A regarding the dates on Caregiver D's background checks. Director A stated they would look for a background check done at time of hire. On 05/07/2024 at 1:21 PM, Surveyor interviewed Director A regarding the date on Caregiver G's background check. Director A stated the 2024 background check was the only one they had. On 05/07/2024 at 3:54 PM, Surveyor discussed concern of background checks not completed at time of hire with Director A, Assistant Director B and Regional Director of Operations C. Director A stated they would look for Caregiver D's and Caregiver G's background checks completed at time of hire and submit it to Surveyor by 4:00 PM on 05/08/2024. As of 05/10/2024 at 12:00 PM, no additional information was received.	N 219		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or	N 432		

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N 432	Continued From page 2 arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the Resident 1's medication administration was appropriate for the resident's needs. RN delegated staff allowed Resident 1 to self-inject his/her insulin subcutaneously through his/her t-shirt rather than cleaning the injection site with an alcohol pad and instructing the resident to inject the insulin subcutaneously directly on skin. Findings include: On 05/07/2024 at 11:57 AM, Surveyor observed Caregiver D check Resident 1's blood sugar, dial the insulin pen to the correct units, prime the insulin pen and hand the insulin pen to Resident 1. Resident 1 self-injected the insulin through his/her left t-shirt sleeve. On 05/07/2024 at 11:58 AM, Surveyor interviewed Resident 1 and Caregiver D. Resident 1 stated s/he discussed self-administering insulin through clothing with his/her doctor. Caregiver D stated Resident 1 had always self-administered insulin through his/her clothing. On 05/07/2024, Surveyor reviewed Resident 1's record. S/he was admitted 11/08/2021.	N 432		

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N 432	Continued From page 3 Diagnoses included type 2 diabetes and dementia without behaviors. Power of Attorney for Health Care document was activated. Physician orders included Novolog 100 units/mL sliding scale insulin inject subcutaneously 3 times daily before meals and Tresiba 200 Units inject 30 Units subcutaneously once daily. Self-Administration of Medications Assessments signed by Regional RN E dated 02/12/2024, 03/12/2024 and 04/17/2024 (summarized): Assessments only completed for self-administration of Novolog and Tresiba insulins. Resident 1 fully capable to identify, state reason for and proper dosage, measure proper dosage, and demonstrate secure storage for each medication, and resident does not require assistance to self-administer medications. Medication Administration Record (MAR): From 04/01/2024-05/07/2024, Caregiver D documented Resident 1's insulin administration 26 times. Individual Service Plan dated 02/24/2024- In the area of Medications- "Resident/tenant self-administers insulin and/or medications ...b. Identify where resident wants shot C. Cleanse area with alcohol prep pad ...5. While keeping the needle pushed tightly against the skin, the resident should depress the plunger & hold it for 10 seconds (count aloud) ..." The ISP did not identify insulin administration through clothing. On 05/07/2024 at 3:54 PM, Surveyor discussed concern of Resident 1 injecting insulin through his/her clothing with Director A, Assistant Director B and Regional Director of Operations C. Director A stated they would check if MD is okay with	N 432		

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N 432	Continued From page 4 Resident 1's method and follow up with Surveyor by 4:00 PM on 05/08/2024. As of 9:00 AM on 05/10/2024, no additional information was received. On 05/09/2024, Surveyors interviewed Regional RN E who stated s/he was unaware Resident 1 was administering insulin through his/her clothing. Regional RN E stated during self-administration assessments Resident 1 required minor cues and during mock injection or real injection self-administered insulin directly on abdomen skin. Regional RN E stated insulin administration through clothing was an ineffective administration especially since clothing has different textures and thickness and was an infection control issue and s/he would never tell staff it was okay to inject insulin through clothing. Regional Director A stated s/he would re-delegate staff for injections and discuss with Resident 1's physician. On 05/10/2024 at 9:46 AM, Surveyor received a call from Vice President of Nursing (VPN)-D who stated the issue with Resident 1 self-administering insulin through clothing was identified some time ago and Director A did not complete a negotiated risk agreement or identify it on Resident 1's ISP. VPN-D stated they had changed their protocol since and Resident 1's ISP matches the protocol. VPN-D stated Resident 1's MD never said it was acceptable for Resident 1 to administer his/her insulin through clothing and staff were to document and notify the MD if it was occurring. VPN-D stated there was no documentation of it occurring or that MD was notified. VPN-D stated Director A, Assistant Director B and team members would be re-educated and Resident 1's MD would be called on 05/10/2024.	N 432		

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N 523	Continued From page 5	N 523		
N 523	83.47(2)(b) Exit diagram. Exit diagram. The disaster plan shall have an exit diagram that shall be posted on each floor of the CBRF used by residents in a conspicuous place where it can be seen by the residents. The diagram shall identify the exit routes from the floor, including internal horizontal exits under par. (f) when applicable, smoke compartments or a designated meeting place outside and away from the building when evacuation to the outside is the planned response to a fire alarm. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the emergency exit diagrams were posted in a conspicuous place where they could be seen by the residents. The emergency exit diagrams were in the kitchen's pantry. Findings include: The facility is licensed as a Class CNA CBRF able to serve up to 20 residents within the client groups of irreversible dementia/Alzheimer's and advanced age. Census on 05/07/2024 was 17. On 05/07/2024 at approximately 10:30 AM, Surveyor was unable to locate the posted emergency exit diagram. On 05/07/2024 at 10:33 AM, Surveyor asked Assistant Director B where the diagram was posted. Assistant Director B stated they were probably in the kitchen since Resident 2 kept pulling them down. At 10:33 AM, Surveyor accompanied Assistant Director B to the kitchen	N 523		

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N 523	Continued From page 6 door. Assistant Director B entered the kitchen then returned to Surveyor with 2 emergency exit diagrams and stated they were in the kitchen's pantry. On 05/07/2024 at 3:54 PM, Surveyor discussed concern of emergency exit diagrams not posted where residents could see them with Director A, Assistant Director B and Regional Director of Operations C. Director A stated they would obtain an encasement to post them in. Cross Reference: N0637 DHS 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways	N 523		
N 637	83.59(1)(g) Proper exit locations, sidewalks, driveways. All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exits, sidewalks and driveways used for exiting shall be kept free of ice, snow, and obstructions. For facilities serving only ambulatory residents, the CBRF shall maintain a cleared pathway from all exterior doors to be used in an emergency to a public way or safe distance away from the building. For facilities serving semi-ambulatory and non-ambulatory residents, a CBRF shall maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2 primary exits from the building. All other required exits shall have at least a cleared pathway maintained to a public way or safe distance from the building. An exit door or walkway to a cleared	N 637		

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N 637	Continued From page 7 driveway leading away from the CBRF also meets this requirement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a barrier-free walkway to a safe distance away from the building was maintained for at least 2 primary exits from the building. Two exterior doors identified as emergency exits led to a fenced courtyard and the gait leading to a safe distance away from the building/fenced courtyard was locked. Findings include: The facility is licensed as a Class CNA CBRF able to serve up to 20 residents within the client groups of irreversible dementia/Alzheimer's and advanced age. Census on 05/07/2024 was 17. On 05/06/2024 at 10:39 AM while touring facility with Assistant Director B, Surveyor observed emergency exits near rooms 9 and 18. The emergency exits led out to the same fenced courtyard (Photo 1) A lockable gait latch with keyhole and touch pad were attached to the gait leading out of the courtyard (Photo 2). The gait was locked when Surveyor attempted to open it. On 05/06/2024 at 10:39 AM, Surveyor interviewed Assistant Director B who stated they keypad had not worked for more than 4 years and Director A had the key. On 05/07/2024 at 10:42 AM, Surveyor interviewed Director A who stated the key for the gait was on his/her key ring, was kept in his/her desk drawer, and his/her office was not locked.	N 637		

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N 637	Continued From page 8 Director A stated there was no gait key on the med passers key ring. Director A stated a keyless system was added to the gait approximately a year ago. On 05/07/2024, Surveyor reviewed the emergency exit diagram. The front door and doors near rooms 9 and 18 were identified 2 of 3 emergency exits (Photo3). On 05/07/2024 at 3:54 PM, Surveyor discussed concern of the locked gate with Director A, Assistant Director B and Regional Director of Operations C. Regional Director of Operations stated the gait could not be locked and they would address it. Cross Reference: N0523 DHS 83.47(2)(b) Exit Diagram	N 637		