

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013220	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/23/2023
NAME OF PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4647 MORMON COULEE RD LA CROSSE, WI 54601		
(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 06/21/2023, Surveyor conducted a standard licensure survey at Care Center. Information for this survey was received and reviewed through 06/23/2023. One deficiency was identified. Census: 4	N 000			
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was screened for clinically apparent communicable disease, including tuberculosis (TB) within 90 days before or 7 days after admission. Findings include:	N 302			

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

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0013220	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/23/2023
NAME OF PROVIDER OR SUPPLIER CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4647 MORMON COULEE RD LA CROSSE, WI 54601		
(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 302	Continued From page 1 On 06/21/2023 at approximately 1:00 PM, Surveyor reviewed Resident 1's record. Resident 1 had an admission date of 05/23/2023. The record did not contain documentation to show Resident 1 was screened for communicable disease, including TB. On 06/21/2023 at approximately 1:15 PM, Surveyor asked Human Services Clinician A if there was a record for Resident 1 that showed him/her to be free of communicable disease, including TB. Human Services Clinician A informed Surveyor that Resident 1 did not need screening for clinically apparent communicable disease including TB due to his/her temporary status at the facility. Surveyor stated that if a health screen was located within 48 hours it should be sent it to the department. No further information was received from the provider regarding Resident 1.	N 302		