STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 10/03/2024, Surveyor conducted a complaint investigation at Liberty Village LLC. The complaint was substantiated. Three deficiencies were identified. One of the deficiencies was a repeat deficiency (See SOD 77DQ12, dated 06/02/2021). Census: 13	N 000		
N 441	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation and record review, the provider did not perform hand washing in accordance with the Centers for Disease Control and Prevention (CDC) standards. This is a repeat deficiency. See Statement of Deficiency (SOD) 77DQ12, dated 06/02/2021. Findings include: According to information found on https://www.cdc.gov/handhygiene/providers/guideline.html, "The Core Infection Prevention and Control Practices for Safe Delivery on All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC)" includes the following recommendations for hand hygiene in healthcare settings: Health care personnel should use alcohol-based	N 441		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 441	Continued From page 1	N 441		

hand rub or wash with soap and water for the following clinical indications:

- Immediately before touching a patient
- Before performing an aseptic task or... handling invasive medical devices
- Before moving from work on a soiled body site to a clean body site on the same patient
- After touching a patient or the patient's immediate environment
- After contact with blood, body fluids, or contaminated surfaces
- Immediately after glove removal

The provider is licensed to serve up to 22 residents within the following client groups: irreversible dementia/Alzheimer's, advanced aged, and physically disabled.

On 10/02/2024, the department received a complaint regarding staff not wearing gloves while serving residents at mealtime.

1.) On 10/03/2024 at 12:15 PM, Surveyor observed Food Service Worker C prepare and plate food in the kitchen. Food Service Worker C removed his/her gloves and, without washing hands, put on new gloves and returned to plating and delivering a plate to a resident in the dining room.

2.) At approximately 12:25, Surveyor observed Caregiver D remove his/her gloves and place them on the counter of the kitchenette on the east wing of the facility. Caregiver D then entered a resident's room and returned to the kitchenette. Without washing hands, Caregiver D put on the same pair of gloves s/he left on the counter prior to going into the resident's room. Caregiver D then plated food and held the food on the spatula

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 441	Continued From page 2 with the same glove while plating the food. Surveyor reviewed the provider's hand washing policy. The policy stated hands are to be washed before putting gloves on and after taking gloves off. During the exit interview on 10/03/2024 at approximately 1:15 PM, Surveyor shared these concerns with Director B. Director B was concerned with the Surveyor's findings especially the observation regarding Caregiver D. Director B stated a refresher hand washing training is scheduled for next week. Director B stated the Surveyor's concerns would be addressed with all staff during the training.	N 441		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure a living environment that was safe, clean, comfortable, and homelike. Findings include: The facility is licensed to serve up to 22 residents within the following client groups: irreversible dementia/Alzheimer's disease, advanced aged,	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 481	Continued From page 3 and physically disabled. On 10/02/2024, the department received a complaint that the return air vents for the heating system in the facility were dirty. On 10/03/2024 at approximately 12:30 PM, Surveyor toured the facility, including the return air furnace vents. The following was observed: 1.) In the employee break room, the return air vent and two heating vents covered with dust and dirt. One of the heating vents appeared to have black mold on its surface. 2.) In the room labeled Theater/Chapel, one of two vents was covered with dirt and dust. On 10/03/2024 at approximately 1:00 PM, Surveyor re-toured the facility with Maintenance Technician (MT) A. Surveyor showed the dust-covered vents to MT A. MT A stated s/he was not aware the vents needed to be cleaned but would clean them immediately.	N 481		
N 650	83.59(4)(b) Delayed egress: locking device sign posted Delayed egress door locks are permitted with department approval only in facilities with a supervised automatic fire sprinkler system and a supervised interconnected automatic fire detection system and shall comply with all of the following: A sign shall be posted adjacent to the locking device indicating how the door may be opened.	N 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 650	Continued From page 4	N 650		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure two delayed egress doors had signs indicating how to operate the door.

Findings include:

The facility is licensed to serve up to 22 residents within the following client groups: irreversible dementia/Alzheimer's disease, advanced aged, and physically disabled.

On 10/02/2024, the department received a complaint regarding the east and west exits in the facility not functioning properly.

On 10/03/2024 at approximately 10:00 AM, Surveyor toured the facility with Maintenance Technician (MT) A. Surveyor observed 2 exit doors with delayed egress mechanisms. One of the doors was located on the east side of the facility and the other was located on the west side of the facility. Both doors were listed as an emergency exits and were lighted with signs and both had emergency flood lighting. Neither door had signs indicating how the doors could be opened. MT A stated s/he was not aware the doors needed a proper sign adjacent to the door that explained how to open the door. One door on the west side of the facility had a sign stating the door should not be opened even though it was an emergency exit. MT A stated egress signs would be posted.

Surveyor re-toured the east side exit with Director B and showed Director B the door did not have the proper sign explaining how to open the door. Surveyor discussed with Director B the west door

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013967	A. BUILDING: _____ B. WING _____	C 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY VILLAGE LLC	200 LIBERTY PLACE TOMAH, WI 54660

(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 650	Continued From page 5 was missing the same sign. Director B noted the information.	N 650		