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| N 000 | Initial Comments<br><br>On 12/13/2023, Surveyor conducted a standard survey at Iberias House Of Hope LLC.<br><br>Eleven deficiencies were identified.<br><br>Census: 6 | N 000 | | |
| N 105 | 83.04(2)(c) Class A non-ambulatory (ANA).<br><br>Class A non-ambulatory (ANA). A class A non-ambulatory CBRF serves residents who are ambulatory, semi-ambulatory or non-ambulatory and who are mentally and physically capable of responding to a fire alarm by exiting the CBRF without any help or verbal or physical prompting.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the provider did not ensure the CBRF (license class ANA) served only residents who were ambulatory, semi-ambulatory or non-ambulatory and who were mentally and physically capable of responding to a fire alarm by exiting the CBRF without any help or verbal or physical prompting.<br><br>Three of 8 residents residing at the CBRF required staff to transfer them using a Hoyer lift transfer and therefore were unable to exit the CBRF without physical assistance in response to a fire alarm.<br><br>Findings include:<br><br>According to DHS 83.47(1), residents identified as "point of rescue" require greater than 4 minutes to evacuate, are instructed to remain in their bedrooms by CBRF staff, and rescued by the fire department. | N 105 | | |

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

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| N 105 | Continued From page 1<br><br>On 12/13/2023 at approximately 8:00 AM, Surveyor observed Resident 2 seated in a wheelchair and Resident 3 seated in an electric wheelchair.<br><br>On 12/13/2023 at 8:48 AM, Surveyor observed Resident 1 lying in bed with a Hoyer lift parked in his/her room.<br><br>On 12/13/2023, Surveyor reviewed the resident roster which stated Resident 1, Resident 2, and Resident 3 were admitted to facility on 08/01/2023 following facility's change of ownership.<br><br>On 12/13/2023 at 9:02 AM, Surveyor interviewed Caregiver B who stated Resident 1 and Resident 3 were transferred using a Hoyer lift and Resident 2 was transferred using a sit-to-stand lift.<br><br>On 12/13/2023 at 9:34 AM, Surveyor interviewed Administrator A who stated any residents using wheelchairs were identified as point of rescue. Surveyor reviewed the facility license and DHS 83.04(2)(c) with Administrator A. Administrator A checked his/her initial license application and stated s/he should have checked Class CNA instead of ANA when completing the application. Surveyor instructed Administrator A on how to correct the license classification with the Department. Administrator A stated s/he would correct it as soon as possible. | N 105 | | |
| N 220 | 83.17(2)(a) Employees screened for communicable disease.<br><br>The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse | N 220 | | |

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| N 220 | Continued From page 2<br>practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure all employees were screened for clinically apparent communicable disease including tuberculosis (TB) within 90 days prior to start of employment for 1 of 2 employees reviewed.<br><br>Caregiver B did not have a TB test prior to employment.<br><br>Findings include:<br><br>On 12/13/2023, Surveyor reviewed Caregiver B's employee record. S/he was hired 10/05/2022. The record contained a Communicable Disease/Tuberculosis Screening Questionnaire dated 10/12/2022. The record did not contain evidence that a 2 step TB test was performed.<br><br>On 12/13/2023, Surveyor discussed concern of no evidence Caregiver B had a TB test prior to employment with Administrator A who stated s/he would look for it and submit it to Surveyor by noon on 12/14/2023. | N 220 | | |

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| N 220 | Continued From page 3<br><br>On 12/14/2023 at 11:44 AM, Surveyor received an email from Administrator A with an attachment including Caregiver B's 10/12/2022 Communicable Disease/Tuberculosis Screening Questionnaire. As of 12/22/2023 at 5:00 PM, no TB test for Caregiver B was received from provider. | N 220 | | |
| N 344 | 83.32(2)(b) Post resident rights, grievance procedure<br><br>Explanation of resident rights, grievance procedure, and house rules. The CBRF shall post copies of resident rights, grievance procedure and house rules in a prominent public place available to residents, employees and guests.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure the grievance procedure and house rules were posted in a prominent public place available to residents, employees and guests.<br><br>Findings include:<br><br>The facility is licensed to serve up to 8 residents within the client groups of developmentally disabled and physically disabled.<br><br>On 12/13/2023 at approximately 10:20 AM, Surveyor and Administrator A were unable to locate postings of the grievance procedure and house rules. Administrator A stated the house rules and grievance procedure were provided to the resident and/or the resident's legal representative with the admission agreement at time of admission. | N 344 | | |

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| N 344 | Continued From page 4<br><br>On 12/13/2023 at 1:02 PM, Surveyor discussed concern of grievance procedure and house rules not posted with Administrator A who stated s/he did not know they had to be posted. Administrator A stated s/he would post them right away. | N 344 | | |
| N 352 | 83.32(3)(h) Rights of Residents: Receive medication<br><br>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure the resident right to receive all medications as prescribed by physician.<br><br>From 11/08/2023-12/13/2023, Resident 2 continued to receive Fluoxetine after discontinuation by physician.<br><br>Findings include:<br><br>On 12/13/2023, Surveyor reviewed Resident 2's record. S/he was admitted 08/01/2023.<br><br>Physician orders included Fluoxetine 20 HCL MG 1 capsule in AM (start 06/15/2023).<br><br>Physicians After Visit Summary dated 11/07/2023 stated " ...Instructions 1. Please discontinue Fluoxetine ...STOP taking these medications | N 352 | | |

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| N 352 | Continued From page 5<br>FLUoxetine 20 MG capsule ..."<br><br>Medication administration record dated 11/01/2023-12/13/2023:<br>From 11/08/2023-12/12/2023, staff documented administration of Fluoxetine 20 HCL MG 1 capsule in AM 35 times.<br><br>On 12/13/2023 at approximately 12:15 PM, Surveyor reviewed Resident 2's 11/07/2023 After Visit Summary and November/December MARs with Administrator A. Administrator A stated Family Member B gave him/her the After Visit Summary 11/07/2023 after taking Resident 2 to the appointment. Administrator A stated the physician sends new orders directly to the pharmacy and the pharmacy changes the MAR. Administrator A stated s/he was confused why pharmacy continued the Fluoxetine. Administrator A stated s/he did not reconcile the Fluoxetine after the appointment.<br><br>On 12/13/2023 at approximately 12:20 PM, Administrator A called Family Member D on speaker phone with Surveyor present. Family Member D stated Resident 2's Fluoxetine was discontinued on 11/07/2023. Family Member D stated since Resident 2 was currently doing very well s/he would like the Fluoxetine continued.<br><br>On 12/13/2023 at 1:02 PM, Surveyor discussed concern of staff administering discontinued Fluoxetine to Resident 2 with Administrator A. Administrator A stated s/he would call the pharmacy to discuss concern.<br><br>On 12/14/2023 at 3:24 PM, Surveyor received an email from Administrator A stating, " ...I spoke with the pharmacy. They said that the doctor never canceled the prescription. [Family Member | N 352 | | |

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| N 352 | Continued From page 6<br>D] is calling the doctor now to ask [him/her] to remove that order because the current meds are working..."<br><br>Cross Reference:<br>N0415 DHS 83.37(2)(d) Documentation Of Medication Administration | N 352 | | |
| N 381 | 83.35(1)(a) Pre-admission and ongoing assessments.<br><br>Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the provider did not ensure an assessment was completed when there was a change in resident needs, abilities or condition.<br><br>Use of bilateral side rails was not assessed following an overall decline in Resident 1's condition.<br><br>Findings include:<br><br>According to the U.S. Food & Drug Administration's Hospital Bed Safety Workgroup, | N 381 | | |

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| N 381 | Continued From page 7<br>"...Strangling, suffocating, bodily injury, or death can occur when patients or parts of their bodies are caught between rails or between the bed rails and mattresses...Regardless of the purpose for which bed rails are being used or considered, a decision to utilize or remove those in current use should occur within the framework of an individual patient assessment.<br>2. Because individuals may differ in their sleeping and nighttime habits, creation of a safe bed environment that takes into account patients' medical needs, comfort, and freedom of movement should be based on individualized patient assessment by an interdisciplinary team...3. Use of bed rails should be based on patients' assessed medical needs and should be documented clearly...Bed rail effectiveness should be reviewed on a regular basis...The patient's chart should include a risk-benefit assessment that identifies why other care interventions are not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the patient.<br>4. Bed rail use for treatment of a medical symptom or condition should be accompanied by a care plan (treatment program) designed for that symptom or condition. The plan should present clear directions for further investigation of less restrictive care interventions. The documentation should describe the attempts to use less restrictive care interventions and, if indicated, their failure to meet patients' assessed needs. 5. Bed rail use for patient's mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan...The care plan should: include educating the patient about possible bed rail danger to enable the patient to make an informed decision; and address options for reducing the | N 381 | | |

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| N 381 | Continued From page 8 | N 381 | | |

risks of the rail use. 6. The process of reducing and/or eliminating existing use of bed rails should be undertaken incrementally using an individualized, systematic, and documented approach..." (Source: "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings" https://www.fda.gov/media/88765/download (retrieval date 12/14/2023)).

On 12/13/2023 at 8:48 AM, Surveyor observed Resident 1 in bed. The bed was placed against a wall. One-quarter bilateral siderails were attached to the bed. The siderail on the wall side of the bed was down and the siderail on the room side of the bed was up.

On 12/13/2023, Surveyor reviewed Resident 1's record. S/he was admitted 08/1/2023 and admitted onto hospice service 10/26/2023.

Combined Assessment/Care Plan (summarized):
In the area of Risks- not a fall risk
In the area of Physical Health- moderate assistance needed with ambulation, stand-by assist with transfers, and independent with repositioning.

On 12/13/2023, Surveyor requested Resident 1's hospice documentation including hospice assessment and care plan from Administrator A. The binder was empty except for 1 blank form.

On 12/13/2023 at 11:30 AM, Surveyor interviewed Administrator A who stated hospice delivered the bed with the siderails attached on 12/11/2023. Administrator A stated s/he did not know the reason for the siderails, and staff put the side rails in the up position whenever Resident 1 was in

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| N 381 | Continued From page 9<br>bed. Administrator A stated s/he would request documentation from hospice.<br><br>On 12/13/2023 at 12:02 PM, Surveyor interviewed Caregiver B who stated Resident 1 was unable to move him/herself in bed.<br><br>On 12/13/2023 at approximately 2:30 PM, Surveyor discussed concern of no assessment or care plan for use of side rails with Administrator A. Administrator A stated hospice shared information verbally but not in writing. Administrator A verbalized an understanding of risk for injury and/or death with the improper use of siderails. Administrator A stated s/he would request hospice remove side rails from Resident 1's bed.<br><br>On 12/14/2023 at 11:44 AM, Surveyor received Resident 1's hospice combined Comprehensive Assessment and Plan of Care Update Report dated 12/13/2023 from Administrator A via email. The hospice assessment/care plan identified need for Broda chair, hospital bed and Hoyer lift, but did not identify need for or include an assessment or instructions for siderails use.<br><br>Cross Reference:<br>N0389 DHS 83.35(3)(d) Service Plans Not Updated Annually Or On Changes<br>N0454 DHS 83.42(1) Resident Record Maintained | N 381 | | |
| N 389 | 83.35(3)(d) Service plans updated annually or on changes<br><br>Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual | N 389 | | |

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| N 389 | Continued From page 10<br>service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the provider did not ensure when there was a change in a resident's needs, abilities or physical or mental condition the individual service plan was reviewed and revised.<br><br>Resident 1's individual service plan (ISP) was not reviewed and revised to include urinary catheter, Hoyer lift transfers, pressure sores, oral infection, supplemental oxygen or hospice services and the provider did not have a copy of hospice's assessment/care plan instructing staff how to care for Resident 1.<br><br>Findings include:<br><br>On 12/13/2023 at 8:48 AM, Surveyor observed Resident 1 lying in bed. A urinary catheter was utilized, oxygen was being administered via nasal cannula and concentrator, and a Hoyer lift was parked in the room.<br><br>On 12/13/2023 at 9:02 AM, Surveyor interviewed Caregiver B who stated s/he was the med passer on 12/13/2023 AM shift. Caregiver B stated Resident 1 was on hospice service, utilized a | N 389 | | |

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| N 389 | Continued From page 11 | N 389 | | |

catheter, and was transferred using a Hoyer lift. Caregiver B stated there were no residents with skin issues.

On 12/13/2023 at approximately 9:15 AM, Surveyor requested Resident 1's record including physician orders, most recent comprehensive assessment, current ISP, and hospice documentation from Administrator A.

On 12/13/2023, Surveyor reviewed Resident 1's record. S/he was admitted 12/01/2022. Face sheet identified 10/26/2023 hospice start date. Diagnoses included urine retention.

Physician orders included Nystatin 100,000 Unit/ml swish and swallow 10 ml by mouth 4 times a day as directed (start date 12/08/2023). Physician orders did not include supplemental oxygen.

Combined initial comprehensive assessment and ISP dated 11/30/2022:
In the area of Toileting- " ...[Resident 1] needs to be cued every two hours to use the bathroom. [Resident 1] has a history of urinary retention, prostatitis and UTI's. Since moving in, [Resident 1] has been ambulatory without the use of [his/her] wheelchair and using the bathroom independently without staff assistance ..."
In the area of Risks- " ...Skin Breakdown Risk Is the client at risk for skin breakdown?..." Box to check "yes" was blank, and there was no box to check "no".
In the area of Physical Health- " ...Mobility Status ...Moderate assistance needed with ambulation ...Stand by assistance is needed when transferring ..."
The combined initial assessment and ISP did not address hospice services, urinary catheter,

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| N 389 | Continued From page 12 | N 389 | | |

oxygen, skin issues, mouth infection or Hoyer lift transfers.

Resident 1's hospice binder contained only 1 blank form.

On 12/13/2023 at 12:02 PM, Surveyor observed Caregiver B administer Nystatin 100,000 Unit/ml to Resident 1's mouth using a toothette and interviewed Caregiver B. Caregiver B stated hospice instructed them to apply the Nystatin with the toothette because Resident 1 was unable to swish and swallow. Caregiver B stated s/he did not know how many liters of oxygen Resident 1 was receiving. Caregiver B checked the top/front and back of the concentrator then stated, "I think 1.5 since that's where the little ball (oxygen flow meter ball) is." Caregiver B stated hospice controlled the oxygen.

On 12/13/2023 at approximately 12:15 PM, Hospice CNA C arrived at facility and informed Surveyor and Caregiver B Resident 1 was to receive 2L of oxygen as needed if appearing confused or short of breath. Hospice CNA C stated Resident 1 did not need the oxygen at that time because s/he did not appear confused or short of breath. Hospice CNA C showed Caregiver B how to read and adjust the settings on the concentrator.

On 12/13/2023 at 11:30 AM, Surveyor interviewed Administrator A who stated Resident 1 had suddenly declined and hospice delivered the oxygen supplies and Hoyer lift on 12/11/2023.

On 12/13/2023 at 1:02 PM, Surveyor discussed concern of Resident 1's ISP not updated when changes occurred. Administrator A stated Resident 1's catheter was started approximately 3

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| N 389 | Continued From page 13<br>months prior to 12/13/2023 and was supposed to be temporary. Administrator A stated hospice shared information verbally but not in writing and s/he would request documentation from hospice.<br><br>On 12/14/2023 at 11:44 AM, Surveyor received Resident 1's hospice documentation via email from Administrator A.<br><br>Hospice's combined comprehensive assessment and care plan dated 12/13/2023, included a RN visit note (last visit note dated 12/13/2023): " ...LAST WEEK PATIENT WAS STANDING IN THE SHOWER TO GET CLEANED UP NOW [S/HE] IS A HOYER LIFT AND A BED BATH. PATIENT HAS INCREASED BRUISING TO [HIS/HER] FEET, SHIN AND KNEE DO [SIC] TO CONTRACTING WHILE IN BED ...HOYER LIFT STARTED 12/3/23. NO LONGER ABLE TO HOLD CUP AND DRINK ON OWN. PATIENT HAS PRESSURE SORES TO ANKLES AND LEGS ...PRN OXYGEN USE CONTINUES ...UNDETERMINED INFECTION IN MOUTH ..."<br><br>Cross Reference:<br>N0381 DHS 83.35(1)(a) PreAdmission And Ongoing Assessments<br>N0454 DHS 83.42(1) Resident Record Maintained | N 389 | | |
| N 415 | 83.37(2)(d) Documentation of medication administration.<br><br>Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or | N 415 | | |

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treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure at the time of medication administration staff documented in the resident record the date and time of medication administration for 2 of 2 residents reviewed.

From 11/01/2023-12/12/2023, staff failed to document administration of scheduled physician ordered treatments (20 times), supplement (13 times), and medications (36 times) to Resident 1.

From 11/01/2023-12/12/2023, staff failed to document administration of scheduled physician ordered medications (29 times) and treatment (7 times).

On 12/13/2023, Surveyor reviewed Resident 1's and Resident 2's records.

Example 1-Resident 1
Resident 1 was admitted 08/01/2023.

Scheduled physician ordered medications included:
House Supplement 1 can 3 times daily (start 09/19/2023); Multivitamin 1 tablet AM (start 12/22/2022); Vitamin D3 25 MCG 1 capsule in morning (start 10/21/2023); Tamsulosin HCL 0.4 MG 2 capsules in evening (start 12/23/2022); Vitamin B-1 in AM (start 02/06/2023); Divalproex

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| N 415 | Continued From page 15<br><br>Sodium 250 MG 2 tablets AM and 3 tablets at bedtime (start date 09/19/2023); Levetiracetam 500 MG 1 tablet twice daily (start date 09/19/2023); Skin-Prep apply topically to heels every shift (start 09/21/2023); and Nystatin 100,000 UNIT/ML swish and swallow 10 ml 4 times daily (start 12/08/2023)<br><br>Medication administration record (MAR) dated 11/01/2023-12/13/2023 AM:<br><br>Staff did not document administration of the following supplement, medications, and treatments:<br><br>House Supplement - 11/11/2023 4:00 PM and 8:00 PM; 11/12/2023 4:00 PM and 8:00 PM; 11/13/2023 AM; 11/29/2023 AM; 12/02/2023 8:00 PM; 12/03/2023 4:00 PM and 8:00 PM; 12/06/2023 AM; 12/10/2023 8:00 PM; 12/11/2023 AM; and 12/12/2023 8:00 AM.<br><br>Multivitamin- 11/13/2023 AM; 11/29/2023 AM; 12/06/2023 AM; 12/11/2023 AM; and 12/12/2023 AM.<br><br>Vitamin D3- 11/13/2023 AM; 11/29/2023 AM; 12/06/2023 AM; 12/11/2023 AM; and 12/12/2023 AM.<br><br>Tamsulosin HCL- 11/11/2023 PM; 11/12/2023 PM; and 12/03/2023 4:00 PM.<br><br>Vitamin B-1- 11/13/2023 AM; 11/29/2023; 12/06/2023 AM; 12/11/2023 AM; and 12/12/2023 AM.<br><br>Divalproex Sodium- 11/11/2023 PM; 11/12/2023 PM; 11/13/2023 AM; 11/29/2023 AM; 12/01/2023 AM; 12/03/2023 8:00 PM; 12/06/2023 AM; | N 415 | | |

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| N 415 | Continued From page 16<br>12/10/2023 8:00 PM; 12/11/2023 AM; and 12/12/2023 AM.<br><br>Levetiracetam- 11/11/2023 PM; 11/12/2023 PM; 11/13/2023 AM; 11/17/2023 AM; 11/22/2023 PM; 11/29/2023 AM; 12/03/2023 8:00 PM; 12/06/2023 AM; 12/10/2023 8:00 PM; 12/11/2023 AM; and 12/12/2023 AM.<br><br>Skin-Prep- 11/11/2023 4:00 PM and 8:00 PM; 11/12/2023 4:00 PM and 8:00 PM; 11/15/2023 8:00 PM; 11/16/2023 4:00 PM and 8:00 PM; 11/22/2023 8:00 PM; 12/02/2023 4:00 PM and 8:00 PM; 12/03/2023 4:00 PM and 8:00 PM; 12/06/2023 8:00 AM; 12/10/2023 8:00 PM; 12/11/2023 8:00 AM; and 12/12/2023 8:00 AM.<br><br>Nystatin- 12/10/2023 8:00 PM; 12/11/2023 8:00 AM; 12/12/2023 8:00 AM and 12:00 PM.<br><br>Example 2-Resident 2<br><br>Resident 2 was admitted 08/01/2023.<br><br>Scheduled physician ordered medications included:<br>Multivitamin 1 tablet AM (start 02/22/2023); Omeprazole 20 MG 1 capsule twice daily (start 03/17/2023); Tamsulosin HCL 0.4 MG 1 capsule in morning (start 03/23/2023); Divalproex 500 MG 2 tablets twice daily (start 04/17/2023); Benztropine 0.5 MG 1 tablet in AM (start 04/22/2023); Carbamazepine 200 MG 2 tablets in AM and 1 in PM (start 09/21/2023); Tamsulosin HCL 0.4 MG 1 capsule in AM; Trazadone HCL 50 MG ½ tablet at bedtime (start 06/18/2023); Miconazole Nitrate 2% apply topically to affected area twice daily (start 09/21/2023); Multivitamin 1 tablet in AM (start 09/21/2023); Omeprazole 20 MG 1 capsule twice daily (start 09/21/2023; and | N 415 | | |

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Risperidone 2 MG 1 capsule twice daily (start 10/22/2023).

MAR dated 11/01/2023-12/13/2023 AM:
Staff did not document administration of the following medications and treatments:

Multivitamin 1 tablet AM- 11/07/2023 AM; and 12/07/2023 AM.

Omeprazole 20 MG- 11/07/2023 AM; 11/18/2023 AM; 11/26/2023 PM; 11/26/2023 PM; 12/04/2023 PM; and 12/07/2023 AM.

Tamsulosin HCL- 11/07/2023 AM; 11/16/2023 AM; and 12/07/2023 AM.

Divalproex- 11/07/2023 AM; and 12/04/2023 PM.

Benztropine- 11/07/2023 AM; and 12/07/2023 AM.

Carbamazepine-11/07/2023 AM; 12/04/2023 PM; and 12/07/2023 AM.

Trazadone- 11/11/2023 PM; 11/12/2023 PM; 12/04/2023 PM; and 12/08/2023 PM.

Risperidone-11/07/2023 AM; 11/11/2023 PM; 11/12/2023 PM; 11/26/2023 PM; 12/04/2023 PM; 12/07/2023 AM; and 12/08/2023 PM.
Miconazole Nitrate- 11/07/2023 AM; 11/11/2023 PM; 11/12/2023 PM; 11/26/2023 PM; 12/04/2023 PM; 12/07/2023 AM; and 12/08/2023 PM.

On 12/13/2023 at 1:02 PM, Surveyor interviewed Administrator A who stated Resident 1's and Resident 2's medication administration was not documented on a back-up paper MAR. On 12/13/2023, Surveyor and Administrator A

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| N 415 | Continued From page 18<br>attempted to review Resident 1's and Resident 2's observation notes for documentation of medication administration. Because there were 150 plus pages of observation notes dated 11/01/2023-12/13/2023 for each of the 2 residents, Surveyor requested Administrator A review the progress notes for documentation of medication administration and list dates/times of the documentation for Surveyor.<br><br>Cross Reference:<br>N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication | N 415 | | |
| N 454 | 83.42(1) Resident record maintained.<br><br>The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following:<br>(a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of | N 454 | | |

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| N 454 | Continued From page 19<br>sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. | N 454 | | |

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 1's record contained hospice documentation.

Resident 1's record did not include hospice documentation including hospice order for supplemental oxygen.

Findings include:

On 12/13/2023 at 8:48 AM, Surveyor observed Resident 1 lying in bed. Oxygen was being administered via nasal cannula and concentrator.

On 12/13/2023 at 9:02 AM, Surveyor interviewed Caregiver B who stated Resident 1 was on hospice service.

On 12/13/2023 at approximately 9:15 AM, Surveyor requested Resident 1's record including physician orders and hospice documentation from Administrator A.

On 12/13/2023, Surveyor reviewed Resident 1's record. S/he was admitted 12/01/2022. Face sheet identified 10/26/2023 hospice start date.

Physician orders did not include an order for supplemental oxygen.

Resident 1's hospice binder was empty except for 1 blank form.

On 12/13/2023 at 1:02 PM, Surveyor discussed concern of hospice documentation missing from Resident 1's record with Administrator A who stated hospice shared information verbally but not

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| N 454 | Continued From page 21<br>in writing and s/he would request documentation from hospice.<br><br>Cross Reference:<br>N0381 DHS 83.35(1)(a) PreAdmission And Ongoing Assessments<br>N0389 DHS 83.35(3)(d) Service Plans Not Updated Annually Or On Changes | N 454 | | |
| N 481 | 83.43(1) Environment safe, clean, and comfortable<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure the living environment was clean and homelike.<br><br>Findings include:<br><br>The facility is licensed to serve up to 8 residents within the client groups of developmentally disabled and physically disabled.<br><br>On 12/13/2023 at 9:21 AM while touring the facility with Administrator A, Surveyor observed the following:<br><br>Example 1- Laundry Room:<br>1 of 2 light bulbs burnt out<br>Dusty sprinkler head (Photo 2) | N 481 | | |

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| N 481 | Continued From page 22<br><br>Example 2- Bathroom 1 near room #1:<br>Dusty ceiling vent (Photo 3).<br>Caulk surrounding the wheelchair accessible shower threshold gasket (to keep water from running out of shower onto bathroom floor) was peeling off, discolored grey and black, and was cracked in places (Photo 4).<br><br>Example 3- Resident 1's room:<br>Dusty sprinkler head (Photo 5)<br><br>Example 4- Bathroom 2 near room #4:<br>Caulk surrounding the wheelchair accessible shower threshold gasket was peeling off and discolored gray and black in spots. The threshold gasket was misshapen in spots (Photo 6).<br>1 of 3 light bulbs burnt out (Photo 7)<br>Dusty ceiling vent (Photo 8)<br><br>Example 5- Resident 3's room:<br>1 of 2 light bulbs burnt out.<br><br>On 12/13/2023 at 9:25 AM, Surveyor interviewed Administrator A who stated the threshold gasket in bathroom 1 was replaced approximately 10/13/2023 but it was not holding up due to wheels rolling over it.<br><br>On 12/13/2023 at 1:02 PM, Surveyor discussed environment with Administrator A who stated staff already dusted the sprinkler heads, light bulbs would be changed and they would try to fix and clean the shower threshold gaskets. | N 481 | | |
| N 488 | 83.44(1)(c) Clothes dryers enclosed and vented<br><br>Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive | N 488 | | |

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rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure the dryer vent tubing was made of rigid material with a fire rating exceeding the temperature rating of the dryer.

The dryer vent was made of flexible tubing.

Findings include:

On 10/13/2023 at 9:18 AM while touring the facility with Administrator A, Surveyor observed flexible vent tubing on the dryer.

On 10/13/2023 at 9:18 AM, Surveyor interviewed Administrator A who stated s/he was not aware the dryer vent was flexible.

On 10/13/2023 at 1:02 PM, Surveyor discussed concern of flexible dryer vent with Administrator A. Surveyor explained the fire rating requirements of dryer vents to Administrator A who stated s/he would discuss the dryer vent with maintenance and either send Surveyor proof the vent met the fire rating requirements by 5:00 PM on 12/14/2023 or have the flexible vent changed to rigid.

On 12/14/2023 at 3:24 PM Surveyor received an email from Administrator A stating maintenance would change the dryer vent to rigid on 12/16/2023.

Cross Reference:

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| IBERIAS HOUSE OF HOPE LLC | 1920 MADERA ST WAUKESHA, WI 53189 |

| (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 488 | Continued From page 24<br>N0640 DHS 83.59(2)(b) Solid Core Wood Doors Or Equivalent | N 488 | | |
| N 640 | 83.59(2)(b) Solid core wood doors or equivalent<br><br>A solid core wood door or an equivalent fire resistive door shall be provided at any interior stair between the basement and the first floor. The door shall have a positive latch and an automatic closing device and normally shall be kept closed. Enclosed furnace and laundry areas with self-closing doors in a split level home may substitute for the self-closing door between the first and second levels. Enclosed furnace and laundry areas shall have self-closing solid core wood doors or an equivalent fire resistive door when located on a common level with resident bedrooms.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure the door to the laundry room, located on same floor as resident bedrooms, had a self-closing mechanism.<br><br>Findings include:<br><br>The facility is licensed to serve up to 8 residents within the client groups of developmentally disabled and physically disabled.<br><br>On 12/13/2023 at approximately 9:25 AM while touring the facility with Administrator A, Surveyor observed the laundry room located on the ground floor with resident bedrooms. The laundry room door did not have a self-closing mechanism and did not self-close when tested by Surveyor.<br><br>On 12/13/2023 at 10:25 AM, Surveyor | N 640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0019048 | A. BUILDING: _____ B. WING _____ | 12/14/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| IBERIAS HOUSE OF HOPE LLC | 1920 MADERA ST WAUKESHA, WI 53189 |

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|---|---|---|---|---|
| N 640 | Continued From page 25<br>interviewed Administrator A who stated s/he was not aware the laundry room door did not self-close.<br><br>On 12/13/2023, at 1:02 PM, Surveyor discussed concern of laundry door not self-closing with Administrator A who stated the door did not self-close when s/he took over after the change of ownership in June 2023. Administrator A stated s/he would have the door fixed as soon as possible.<br><br>Cross Reference:<br>N 0488 DHS 83.44.(1)(c) Clothes Dryers Enclosed And Vented | N 640 | | |