Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014173	A. BUILDING: _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURT STREET HOUSE (THE)	**422 E COURT ST VIROQUA, WI 54665**

(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
M 000	INITIAL COMMENTS On 03/13/2024, Surveyor conducted a complaint investigation at The Court Street House. The complaint was substantiated. Two deficiencies identified. Census: 4	M 000		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 1's Individual Service Plan (ISP) was updated with a description of the services the provider would offer to meet Resident 1's needs related to suicidal ideation. On 02/29/2024, Resident 1 was able to secure	M 424		

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
	0014173	A. BUILDING: _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURT STREET HOUSE (THE)	422 E COURT ST VIROQUA, WI 54665

(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
M 424	Continued From page 1	M 424		

his/her insulin and inject his/her insulin in an attempt to commit suicide.

Findings include:

On 03/13/2024 at approximately 10:00 AM, Surveyor reviewed Resident 1's record. The record included a Behavior Support Plan (BSP). authored by Resident 1's prior assisted living. There were no updates in the BSP regarding Resident 1's suicide attempt (overdosing on insulin) by the current provider. Resident 1's record included an ISP. The August 2023 ISP did not indicate Resident 1 had tried to commit suicide in August of 2023 by using his/her insulin as a way to overdose. The ISP also did not include the most recent attempt. The ISP did not include a description of services or interventions if Resident 1 attempted suicide by using medication such as insulin.

On 03/13/2023 during an interview with Manager A at 10:10 AM, Manager A stated Resident 1 "has a lot of struggles" and is "emotionally up and down." Manager A also described Resident 1 as being at risk for suicide and self-harm. Manager A explained Resident 1 attempted suicide by overdosing shortly after admission on or around August 2023, and again on 02/29/2024.

On 03/13/2024 at approximately 11:00 AM, Surveyor reviewed Resident 1's most current ISP with Manager A. Surveyor did not find information in the ISP regarding needs and individualized interventions related to suicide risk. Manager A stated the ISP was not updated with the current suicidal attempts of Resident 1. Manager A stated staff left the insulin pen unlocked in the staff room and Resident 1 grabbed the insulin and injected his/herself. Manager A stated s/he was not sure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014173	A. BUILDING: _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURT STREET HOUSE (THE)	422 E COURT ST VIROQUA, WI 54665

(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
M 424	Continued From page 2 how much insulin Resident 1 injected. Manager A stated s/he needed to update the BSP and ISP for Resident 1.	M 424		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not ensure Resident 1 received all prescribed medications in the dosage and interval prescribed by Resident 1's physician. Findings include: On 03/13/2024, Surveyor conducted a complaint investigation related to medication administration. At approximately 10:00 AM, Surveyor reviewed the record of Resident 1. Resident 1 was admitted in August of 2023. Resident 1 is diagnosed with anxiety disorder, depression, and diabetes. Resident 1 is not his/her own decision maker and has a legal representative. At approximately 12:30 PM on 03/13/2024, Surveyor interviewed Manager A. Manager A stated that on 02/29/2024, Resident 1 grabbed his/her insulin pen and injected his/herself with what Resident 1 said was 50 units of fast acting	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014173	A. BUILDING: _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURT STREET HOUSE (THE)	422 E COURT ST VIROQUA, WI 54665

(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
M 582	Continued From page 3 Humalog insulin. Resident 1 stated s/he did this to overdose. Staff did not know the exact amount of insulin taken by Resident 1. Resident 1 was monitored by staff until blood sugar levels stabilized. Manager A said his staff "screwed" up and left the insulin and pen unlocked on top of the desk in the staff office. Manager A stated Resident 1 saw the medication on the desk and grabbed it and self-administered the insulin. Manager A stated s/he was not sure if Resident 1 self-administered the medication but Resident 1 was administered 20 units by staff in the morning of 02/29/2024. Manager A stated the insulin was supposed to be handed to the bus driver and not left unattended on the staff desk. Manager A stated Resident 1 had done this one other time shortly after moving into the facility in August of 2023. Manager A stated s/he did not know the dose Resident 1 self-administered.	M 582		