STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016797	A. BUILDING: _____ B. WING _____	R-C 08/09/2023

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WASHINGTON HEIGHTS MANOR II	1062 W GREENWOOD TERRACE MILWAUKEE, WI 53224

(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 08/09/2023, Surveyor completed a complaint investigation and verification visit at Washington Heights Manor II for Statement of Deficiency (SOD) 80WS11, and SOD 1YX212. Six deficiencies were identified. Five of the 6 deficiencies are cited for the 3rd time. See SOD 1YX211, dated 12/14/2021 and SOD 1YX212, dated 06/28/2022. Deficiencies identified in 80WS11, dated 09/28/2022, were determined to be corrected. The complaint was unsubstantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 7	{N 000}		
{N 196}	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and staff interview, the provider and its operation did not comply with all laws governing the Community-Based Residential Facility (CBRF). As a result of a verification survey, 6 deficiencies were identified. Five of the 6 were repeat violations and were cited for the 3rd time. Deficiencies were identified in the areas of health screening of residents and caregivers, medication administration and storage, and safety. This had the potential to negatively affect 7 of 7 residents. This deficiency is being cited for the 3rd time. See Statements of Deficiency (SOD) 1YX211, dated 12/14/2021 and SOD 1YX212, dated 06/28/2022.	{N 196}		

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

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{N 196}	Continued From page 1 Findings include: This facility is licensed to serve up to 8 residents in the client groups' developmentally disabled, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, traumatic brain injury, and advanced age. On 6/27/2022, Surveyor initiated a verification survey. The survey resulted in 6 deficiencies. Five of the 6 deficiencies are being cited for the 3rd time. DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws (cited for 3rd time) DHS 83.17(2)(a) Employees Screened For Communicable Disease (cited for a 3rd time) DHS 83.28(4)a) Resident Health Screening and Documentation (cited for a 3rd time) DHS 83.37(1)(e) Medication Regimen, Administration Review (cited for 3rd time) DHS 83.55(6)(b) Bath and Toilet Areas: Water Temperature (cited for 3rd time) DHS 83.59(2)(b) Solid Core Wood Doors or Equivalent On 06/27/2023, Surveyor reviewed department documents and identified the provider was issued SOD IYX212, dated 06/28/2022, on 10/10/2022. Along with the SOD was the Notice and Order Letter, which identified Special Orders. The letter stated, "1. Pursuant to Wis. Stat. §§ 50.03(5g) (b)3 and (b)6, the facility will immediately ensure that hot water in all areas accessible to residents does not exceed safe temperatures. The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents	{N 196}		

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{N 196}	Continued From page 2	{N 196}		

shall be automatically regulated by valves and may not exceed 115°F:
WITHIN 5 DAYS of this notice, the facility will develop (or revise) and implement a written procedure for routine monitoring of hot water temperatures.
The written procedure will include specific measures the facility will take if recorded water temperatures exceed safe levels.
Monitoring will be documented and records will be made available to Department representatives upon request.
2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., within 7 days of receipt of this notice, the CBRF will provide the legal representative and case manager (if any) for each current resident, with a copy of Statement of Deficiency (SOD) #1YX212 and a copy of this Notice and Order letter. The licensee shall retain documentation, acceptable to the Department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from each legal representative and case manager (if any). The documentation required by Order #2 will be available to department representatives upon request."

On 08/09/2023 at approximately 4:00 p.m., Surveyor interviewed Administrator A and Registered Nurse (RN) N. As a result of this verification survey, 5 of 6 deficiencies were cited for the 3rd time, including this deficiency.
Surveyor asked Administrator A if s/he was aware of the Special Orders contained in the Notice and Order letter dated 10/10/2022. Administrator A stated "yes." Administrator A thought the procedure had been sent to Surveyor. Administrator A stated s/he would send the procedure by tomorrow.
Surveyor asked Administrator A and RN N if the

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{N 196}	Continued From page 3 legal representative and case manager (if any) for each current resident, was provided with a copy of Statement of Deficiency (SOD) #1YX212 and a copy of this Notice and Order letter as requested in the Special Orders. Administrator A stated it was completed. Surveyor asked for documentation to verify compliance with Order #2. Administrator A stated everything was done verbally and there was no documentation. As of 08/11/2023, the procedure for routine monitoring of hot water temperatures had not been received.	{N 196}		
{N 220}	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 4 employee records had documentation from a physician, a registered nurse, or a physician's assistant indicating the employee had been screened, within 90 days before the start of providing service, for clinically	{N 220}		

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{N 220}	Continued From page 4 apparent communicable disease, including tuberculosis (TB). Caregiver I, Caregiver J, Caregiver K, and Caregiver L were not screened for communicable disease including TB within 90 days before the start of providing care. This deficiency is being cited for the 3rd time. See Statements of Deficiency (SOD) 1YX211, dated 12/14/2021, and SOD 1YX212, dated 06/28/2022. Findings include: On 06/27/2023 at approximately 3:15 p.m., a review of employee records revealed the following: Caregiver I was hired 01/11/2023 and started to provide services on 01/15/2023. Caregiver I's record contained evidence s/he was screened for clinically apparent communicable disease on 01/20/2023; however, it was completed 5 days after starting to provide services and not within the 90 days required before the start of providing service. Caregiver I's record did not contain evidence of being screened for TB. Caregiver J was hired 06/15/2023 and started to provide services on 06/21/2023. Caregiver J's record contained evidence s/he was screened for clinically apparent communicable disease on 06/29/2023; however, it was completed 8 days after starting to provide services and not within the 90 days required before the start of providing service. Caregiver J's record did not contain evidence of being screened for TB.	{N 220}		

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{N 220}	Continued From page 5 Caregiver K was hired 06/01/2023 and started to provide services on 06/01/2023. Caregiver K's record contained evidence s/he completed and signed a form to screen for clinically apparent communicable disease on 05/30/2023; however, it was not reviewed and signed by Registered Nurse (RN) N until 06/29/2023, 28 days after starting to provide services and not within the 90 days required before the start of providing service. Caregiver K's record did not contain evidence of being screened for TB. Caregiver L was hired 01/09/2023 and started to provide services on 01/13/2023. Caregiver L's record contained evidence s/he completed and signed a form to screen for clinically apparent communicable disease on 01/21/2023; however, it was not reviewed and signed by Registered Nurse (RN) N until 01/23/2023, 10 days after starting to provide services and not within the 90 days required before the start of providing service. Caregiver K's record did not contain evidence of being screened for TB. On 08/09/2023 at approximately 4:00 p.m., Surveyor interviewed Administrator A and Registered Nurse (RN) N. Administrator A reported s/he thought the communicable disease screen could have been completed up to 7 days after starting to provide services. RN N used a form titled, "Communicable Disease/Tuberculosis Screening Questionnaire." The questionnaire had screening questions for the employee to answer regarding communicable disease and tuberculosis. RN N then reviewed and signed the form. Surveyor asked RN N for the screening for TB results. RN N stated s/he reviewed the answers to the questions, and if there were no	{N 220}		

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{N 220}	Continued From page 6 concerns, s/he signed off the employee was free from communicable diseases and TB. RN N reported s/he thought if the answers to the form did not indicate any concerns, RN N did not need to do any referral for further testing. RN N confirmed s/he did not have staff complete a skin test, blood test, or chest x-ray to confirm they did not have TB. Administrator A and RN N stated they did not understand the code.	{N 220}		
{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 4 of 4 residents' (Resident 1, Resident 3, Resident 5, and Resident 6) records contained documentation by a physician, physician assistant, or registered nurse to show evidence of being screened for communicable disease, including tuberculosis	{N 302}		

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{N 302}	Continued From page 7 (TB), and documented the results of the screening within 90 days before or 7 days after admission. Resident 1 had not been screened for communicable disease until 07/10/2023, over 5 years since admission. Resident 3 has not been screened for communicable disease including TB since admission, almost 20 months. Residents 1 and 3 were identified in SODs 1YX211, dated 12/14/2021 and SOD 1YX212, dated 06/28/2022. Resident 5 has not been screened for TB since admission, almost 2 months ago. Resident 6 was initially admitted on 11/19/2022 to another facility operated by Administrator/Licensee A. Resident 6 was admitted to this facility on 06/29/2023. Provider unable to locate any documentation of screening for communicable disease, or evidence of TB screening results. This deficiency is being cited for the 3rd time. See Statements of Deficiency (SOD) 1YX211, dated 12/14/2021 and SOD 1YX212, dated 06/28/2022. Findings Include: On 07/05/2023 at approximately 2:00 p.m., Surveyor reviewed resident records. The following was identified: Example 1 - Resident 1 Resident 1 was admitted on 03/09/2018. Resident 1's record did not contain documentation of screening for communicable	{N 302}		

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{N 302}	Continued From page 8 disease. On 07/10/2023 at approximately 9:33 a.m., Surveyor informed Administrator A the screening for communicable disease was not in the record. On 07/10/2023 at 7:15 p.m., Surveyor received an email from Administrator A. The email contained documentation Resident 1 was screened for communicable disease by RN N on 07/10/2023, the day Surveyor informed Administrator A the documentation was missing. As a result, Resident 1 had not been screened for communicable disease since admission for over 5 years. Example 2 - Resident 3 Resident 3 was admitted on 11/19/2021. Resident 3 was admitted on 03/09/2018. Resident 3's record did not contain documentation for screening of communicable disease, or evidence of TB screening results. On 07/10/2023 at 7:15 p.m., Surveyor received an email from Administrator A. The email contained documentation Resident 3 was screened for communicable disease by RN N on 07/10/2023, the day Surveyor informed Administrator A the documentation was missing. As a result, Resident 3 had not been screened for communicable disease including TB since admission, almost 20 months. Example 3 - Resident 5 Resident 5 was admitted on 06/12/2023. Resident 5's contained documentation of screening for communicable disease on 06/09/2023; however, there was no evidence of being screened for TB. A note in Resident 5's record stated a TB test was to be completed the week of 06/12/2023. Surveyor gave Administrator A until 07/11/2023 to provide the documents. As of 08/09/2023, no	{N 302}		

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{N 302}	Continued From page 9 documentation had been received. Example 4 - Resident 6 Resident 6 was initially admitted on 11/19/2022 to another facility operated by Administrator A. Resident 6 was admitted to this facility on 06/29/2023. Resident 6's record did not contain documentation for screening of communicable disease, or evidence of TB screening results. On 07/10/2023 at approximately 11:34 a.m., Administrator A informed Surveyor RN N was to look for the admission paperwork from the previous facility specifically documentation of screening for communicable disease, including TB. As of 08/09/2023, no documentation had been received. On 08/09/2023 at approximately 4:00 p.m., Surveyor interviewed Administrator A and RN N. Administrator A stated s/he made sure the required documentation was received before a resident was admitted and added some of the residents came from other facilities or a nursing home. Administrator A reported s/he was going to look for the records and would provide what s/he could locate via email. RN N reported s/he used a form titled, "Communicable Disease/Tuberculosis Screening Questionnaire." The questionnaire had screening questions for the resident to answer regarding communicable disease and TB. RN N then reviewed and signed the form. Surveyor asked RN N for the screening for TB results. RN N stated s/he reviewed the answers to the questions, and if there were no concerns, s/he signed off the resident was free from communicable diseases and TB. Surveyor asked how do you determine a resident does not have TB without doing a skin test, blood test, or chest	{N 302}		

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{N 302}	Continued From page 10 x-ray? RN N reported s/he thought if the answers to the form did not indicate any concerns, RN N did not need to do any referral for further testing. RN N confirmed s/he did not require residents to have a skin test, blood tests, or chest x-ray to ensure they were free from TB. As of 08/11/2023, no further information had been submitted.	{N 302}		
{N 404}	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an onsite review of the CBRF's (Community-Based Residential Facility)	{N 404}		

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{N 404}	Continued From page 11 medication administration and medication storage systems was completed by a physician, pharmacist, or registered nurse since the last survey on 12/14/2021. This deficiency is being cited for the 3rd time. See Statements of Deficiency (SOD) 1YX211, dated 12/14/2021 and SOD 1YX212, dated 06/28/2022. Findings include: On 07/05/2023, at approximately 2:00 p.m., Surveyor requested the annual onsite reviews of the facility's medication storage system. Manager H stated Registered Nurse N (RN N) completed them and did not believe the reviews were kept in the facility. On 07/10/2023 at 9:57 a.m,. Surveyor sent an email to Administrator A requesting the annual onsite review of medication storage and administration. On 07/11/2023 at 5:41 p.m., an email was received containing documentation of medication administration observations by RN N for Caregivers J and K; however, the documentation was completed on 06/29/2023, 2 days after Surveyor began the verification survey; consequently, the annual review of medication administration had not been completed since SOD 1YX211, dated 12/14/2021 was issued. No documentation was received to indicate the annual review of the medication storage system was completed since SOD 1YX211, dated 12/14/2021 was issued. On 08/09/2023 at approximately 4:00 p.m., Surveyor interviewed Administrator A and RN N. RN N stated the medication observation forms	{N 404}		

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{N 404}	Continued From page 12 were submitted. RN N confirmed s/he completed the reviews after the start of the verification visit. RN N stated s/he planned to do the medication administration reviews with staff every 3 months. Administrator A reported the pharmacy usually completed it. Administrator A reported s/he would follow up to see if they completed it, but if Surveyor did not receive it via email, then it was not completed. Moving forward, Administrator A stated RN N would do the medication storage system reviews.	{N 404}		
{N 617}	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a safe environment for 7 of 7 residents. The water temperature at 2 of 2 bathroom sink faucets used by residents had a temperature reading exceeding 115 degrees Fahrenheit (F.), creating a risk for burns. The temperature readings registered between 120 and 121 degrees F. This deficiency is being cited for a 3rd time. See Statement of Deficiencies (SOD) 1YX211, dated 12/14/2021, and SOD 1YX212, dated 06/28/2022.	{N 617}		

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{N 617}	Continued From page 13 Findings include: The facility has a licensed capacity to care for 8 adults in the population groups advanced aged, traumatic brain injury, developmentally disabled, emotionally disturbed/mental illness, and irreversible dementia/Alzheimer's. On 06/27/2023 at approximately 1:15 p.m., Surveyor conducted a tour of the facility with Manager H. The facility floor plan identified bedrooms and bathrooms with numbers. Surveyor tested the water temperature at 2 bathroom sink faucets. Surveyor and Manager H identified the water temperature at the sink faucet in Bathroom 1 (next to the facility office) was 121 degrees F. The water temperature at the sink faucet in Bathroom 3 (near the laundry room) was 120 degrees F. Surveyor observed 7 residents ambulating independently and moving freely throughout the home with access to the water at the kitchen and bathroom faucets. On 06/27/2023 at approximately 3:14 p.m., Surveyor interviewed Manager H. Manager H stated s/he monitored and documented water temperatures monthly. The documentation for January 2023 through June 2023 revealed the water temperatures were 114 degrees F for each month. Manager H stated s/he would contact maintenance and have the water temperature adjusted. On 07/10/2023 at approximately 11:34 a.m., Surveyor interviewed Administrator A. Administrator A stated the hot water heater	{N 617}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016797	A. BUILDING: _____ B. WING _____	R-C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{N 617}	Continued From page 14 temperature had been adjusted. Surveyor asked if there was a policy or procedure for monitoring water temperatures. Administrator A stated Human Resources O had it and Administrator A stated s/he would send to Surveyor. As of 08/11/2023, the procedure for routine monitoring of hot water temperatures had not been received.	{N 617}		
N 640	83.59(2)(b) Solid core wood doors or equivalent 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. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the door leading from the main level to the basement had a positive latch and automatic closing device for 1 of 1 basement door. Findings include: On 06/27/2023 at approximately 1:40 p.m., Surveyor observed the door leading to the basement did not close automatically when opened. Surveyor did not observe any hardware	N 640		

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N 640	Continued From page 15 to facilitate automatic closing of the basement door. On 08/09/2023 at approximately 4:00 p.m., Surveyor interviewed Administrator A and Registered Nurse N about the basement door. Administrator A was not aware the basement door did not self-close. Administrator A stated the hinges on the door contained a built-in self-closing feature and must have worn out. Administrator A would inform maintenance and have it repaired.	N 640		