STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110002	A. BUILDING: _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC HOUSE	202 N PATERSON ST MADISON, WI 53703

(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 08/15/2024, Surveyors conducted a complaint investigation at ARC House. Eight deficiencies were identified. Complaint was substantiated. Census: 11	N 000		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by:	N 239		

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
	110002	A. BUILDING: _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC HOUSE	202 N PATERSON ST MADISON, WI 53703

(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 239	Continued From page 1 Based on interview and record review, the provider did not ensure 2 of 3 staff reviewed obtained all department approved training as required. Case Manager B's record did not contain evidence of training in first aid and choking within 90 days after starting employment. Case Manager C did not have training in fire safety, in first aid and choking within 90 days after starting employment. Case Manager C, who had responsibilities that would create exposure to blood, body fluids or other moist body substances, did not have training in standard precautions prior to assuming these duties. Findings include: On 07/15/2024, the Department received a concern alleging staff were not receiving adequate training. On 08/15/2024, Surveyor reviewed Case Manager B's and Case Manager C's record with Program Manager A. Case Manager B was hired on 12/27/2023. Case Manager B's record did not include department approved training in first aid and choking. Surveyor reviewed the Community-Based Care and Treatment training registry and Case Manager B was not listed for first aid and choking. On 08/15/2024, at approximately 2:00 PM, Surveyor interviewed Case Manager B. Case Manager B stated s/he had a certificate in first aid and CPR (cardiopulmonary resuscitation), which	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110002	A. BUILDING: _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC HOUSE	202 N PATERSON ST MADISON, WI 53703

(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 239	Continued From page 2 had since expired, that had not completed through the department program. Case Manager B stated s/he was not a practitioner, registered nurse, or a licensed practical nurse. Case Manager C was hired on 10/30/2023. Case Manager C's record did not include department approved training in fire safety, first aid and choking, or standard precautions. Surveyor reviewed the Community-Based Care and Treatment training registry and Case Manager C was not listed for fire safety, first aid and choking, or standard precautions. On 08/15/2024, at approximately 2:30 PM, Surveyor interviewed Program Manager A. Program Manager A stated s/he would review all employee files to ensure they had the required trainings.	N 239		
N 346	83.32(3)(b) Rights of Residents: Confidentiality In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Confidentiality. Confidentiality of health and personal information and records, and the right to approve or refuse release of that information to any individual outside the CBRF, except when the resident is transferred to another facility or as required by law or third-party payment contracts and except as provided in s.146.82(2) and (3), Stats. The CBRF shall make the record available to the resident or the resident ' s legal representative for review. Copies of the record shall be made available within 30 days, if requested in writing, at a cost no greater than the cost of reproduction.	N 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110002	A. BUILDING: _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC HOUSE	202 N PATERSON ST MADISON, WI 53703

(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 346	Continued From page 3 This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure resident information was kept secured and confidential. Surveyor observed resident private information left posted throughout the facility. Findings Include: On 07/15/2024, the Department received a concern alleging the provider was violating resident HIPAA (Health Insurance Portability and Accountability Act) rights. On 08/15/2024, at approximately 11:40 AM, Surveyor toured the facility and observed: -Bulletin board, next to the entrance door, contained each resident's "Flow Sheet," which identified their daily schedule. Resident 2's and Resident 5's "Flow Sheet" contained their last name. -Bulletin board, in the office where residents receive their medications, each resident's picture was hung up with their department of corrections identifying number. -Office upstairs, which was unlocked, contained stacks of folders of previous residents. These folders contained full names, birthdates, discharge summary's, social security numbers, and session notes. -Office downstairs, contained folders in a rack with each case managers name written on it. Resident assignments and notes are contained in each folder which are easily accessible by easily reaching through the door. A resident could take the folder and/or items out of the folder that does not belong to them without being noticed.	N 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110002	A. BUILDING: _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC HOUSE	202 N PATERSON ST MADISON, WI 53703

(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 346	Continued From page 4 On 08/15/2024, at approximately 2:30 PM, Surveyor interviewed Program Manager A. Program Manager A stated s/he understood and would immediately address the concerns.	N 346		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not prepare and implement a temporary service plan for 2 of 2 residents (Resident 2 and Resident 3) upon admittance. Findings include: The facility is licensed as a Class AA (ambulatory) CBRF (community-based residential facility) able to serve up to 15 residents within the client groups of correctional clients and alcohol/drug dependent. On 07/15/2024, the Department received a concern alleging improper documentation of residents. On 08/15/2024, Surveyor reviewed Resident 2's and Resident 3's record. Resident 2 was admitted 03/06/2024 and his/her record did not contain a temporary service plan. Resident 3 was admitted 05/08/2024 and his/her	N 385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110002	A. BUILDING: _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC HOUSE	202 N PATERSON ST MADISON, WI 53703

(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 385	Continued From page 5 record did not contain a temporary service plan. On 08/15/2024, at approximately 1:45 PM, Surveyor interviewed Program Manager A. Program Manager A stated s/he had noticed that resident files had incomplete documentation. On 08/15/2024, at approximately 2:00 PM, Surveyor interviewed Case Manager B. Case Manager B stated s/he was responsible for typing up Resident 2's and Resident 3's temporary care plan but stated s/he had not been trained on how to complete the forms. Case Manager B stated s/he had just recently received that training and s/he had completed the forms but had not had time to upload them into the software program.	N 385		
N 415	83.37(2)(d) Documentation of medication administration. 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 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 observation, record review, and interview, the provider did not ensure proper documentation of the Medication Administration	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110002	A. BUILDING: _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC HOUSE	202 N PATERSON ST MADISON, WI 53703

(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 415	Continued From page 6 Record (MAR) for 1 of 2 residents reviewed. Resident 4's MAR contained blanks where medication administration should have been documented. Findings include: On 07/15/2024, the Department received a concern alleging resident medication administration was not being documented correctly. On 08/15/2024, at approximately 1:45 PM, Program Manager A and Case Manager D showed Surveyor where resident medications were stored. Program Manager A stated staff are not trained in medication administration, as staff do not dispense meds. Program Manager A stated staff hand residents their medications, in their containers, and only write down what medications have been administered. On 08/15/2024, Surveyor reviewed Resident 4's August MAR, dated 08/07/2024 to 08/15/2024, which documented: "Bupropion HCL - Take 1 tablet by mouth every morning with 300 MG (milligram) tab for a total of 450 MG." Bupropion HCL 300 MG - Take 1 tablet once daily." The medications were not documented as administered on 08/13/2024 with no rationale. On 08/15/2024, at approximately 2:30 PM, Surveyor interviewed Program Manager A. Program Manager A stated s/he would review the documentation.	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110002	A. BUILDING: _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC HOUSE	202 N PATERSON ST MADISON, WI 53703

(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 483	Continued From page 7	N 483		
N 483	83.43(2)(b) Clean, comfortable mattress and pad. Bedroom furnishings. If a resident does not provide the resident ' s own bedroom furnishings, the CBRF shall provide all of the following: A clean, comfortable mattress covered with a mattress pad and when necessary, waterproof covering. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure residents had a comfortable mattress. Findings include: On 08/15/2024, at approximately 1:30 PM, Surveyor toured the facility. Surveyor observed beds in 3 different resident bedrooms, that when touched, one could easily feel the springs in the mattress. On 08/15/2024, at approximately 2:15 PM, Surveyor interviewed Program Manager A. Program Manager A stated the concern had been recently discussed with management and new mattresses were going to be ordered. Program Manager A did not have current documentation to show that this process had begun.	N 483		
N 500	83.45(4) Pest control. Pest control. The CBRF shall implement safe, effective procedures for control and extermination of insects, rodents and vermin. This Rule is not met as evidenced by:	N 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110002	A. BUILDING: _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC HOUSE	202 N PATERSON ST MADISON, WI 53703

(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 500	Continued From page 8 Based on record review and interview, the licensee did not implement a safe, effective procedure for the control and elimination of insects. The provider had bedbugs in the facility and extermination was delayed. Findings include: On 08/15/2024, at approximately 1:30 PM, Surveyor interviewed Program Manager A. Program Manager A stated the facility had been recently sprayed for bedbugs on 08/02/2024. Program Manager A stated there still had been siting of bedbugs, but the exterminator informed us, we could see activity for up to 3 weeks. Program Manager A stated the home had been sprayed for bedbugs also prior to 03/2024. Program Manager A stated, "Residents had shown signs of what could have been bedbug bites, but management did not think they were bedbug bites until I saw a bedbug crawling on the couch in the session room." On 08/15/2024, at approximately 2:05 PM, Surveyor interviewed Case Manager (CM) B. CM B stated there had been an ongoing problem with bedbugs in the facility. CM B stated, "Residents were appearing with bite marks all over their body, but nobody thought they were bedbug bites." CM B stated the facility had been sprayed for bedbugs months ago and there continued to be an infestation, and the facility was sprayed again on 08/02/2024. On 08/15/2024, at approximately 2:30 PM, Surveyor interviewed Program Manager A. Surveyor asked how the provider was controlling the bedbugs from spreading outside of the home since residents cycled through the home approximately every 30 to 90 days and one	N 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110002	A. BUILDING: _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC HOUSE	202 N PATERSON ST MADISON, WI 53703

(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 500	Continued From page 9	N 500		

resident was moving out on the day of survey. Program Manager A stated, "The resident that is discharging today kept most of [his/her] belongings in the plastic bags from when the facility had been exterminated." Surveyor requested the extermination paperwork for 2024. Program Manager A stated s/he would get that documentation to the Surveyor.

As of 08/16/2024 at 5:00 PM, Surveyor did not receive any documentation.

According to the Illinois Department of Public Health's guidance for managing bed bugs in health care facilities, which is referenced in the Department's "Assisted Living: Standards of Practice Resources": " Confirming a bed bug infestation is the first step toward controlling them. When bed bugs are suspected, specimens should be collected and submitted to entomologists or pest management professionals qualified to identify them. Caregivers, launderers, maintenance staff and others should be trained to recognize and report bed bugs and their signs. ...When bed bugs are discovered in a patient room, if possible the patient(s) should be bathed and showered, clothes changed, and transferred to another room ... Waiting rooms, visitor lounges, common areas, laundry rooms, and equipment such as wheelchairs and food carts, should be regularly inspected for bed bugs." There is also the recommendation that, "An experienced pest management professional should inspect and treat as needed all areas where bed bugs are suspected ..." (Source: Illinois Department of Public Health Website, Prevention & Control: Bed Bugs in Health Care Facilities, no date, http://www.idph.state.il.us/envhealth/BedBugs_HealthCareFacilities.pdf (retrieval date: August 16,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110002	A. BUILDING: _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC HOUSE	202 N PATERSON ST MADISON, WI 53703

(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 500	Continued From page 10 2024).).	N 500		
N 523	83.47(2)(b) Exit diagram. Exit diagram. The disaster plan shall have an exit diagram that shall be posted on each floor of the CBRF used by residents in a conspicuous place where it can be seen by the residents. The diagram shall identify the exit routes from the floor, including internal horizontal exits under par. (f) when applicable, smoke compartments or a designated meeting place outside and away from the building when evacuation to the outside is the planned response to a fire alarm. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the emergency exit diagrams were posted in a conspicuous place where they could be seen by the residents. The upstairs emergency exit diagram was located by the upstairs office, and not viewable for 4 resident bedrooms. The downstairs emergency exit diagram was located in the kitchen dining room, and not viewable for 2 resident bedrooms and the community/session room. Findings include: The facility is licensed as a Class AA (ambulatory) CBRF (community-based residential facility) able to serve up to 15 residents within the client groups of correctional clients and alcohol/drug dependent. On 07/15/2024, the Department received a concern alleging fire evacuation routes were not	N 523		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110002	A. BUILDING: _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC HOUSE	202 N PATERSON ST MADISON, WI 53703

(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 523	Continued From page 11 posted appropriately throughout the facility. On 08/15/2024, at approximately 1:30 PM, Surveyor toured the facility. Surveyor observed an emergency exit diagram upstairs, located near the office and one bedroom. The exit diagram was not visible by the four other bedrooms located upstairs. Surveyor observed an emergency exit diagram downstairs, in the dining room, which was not visible for residents who were in the community/session room or in the 2 bedrooms located on the main level. On 08/15/2024, at approximately 2:15 PM, Surveyor interviewed Program Manager A. Program Manager A stated s/he would create additional emergency exit diagrams and place them throughout the facility.	N 523		
N 639	83.59(2)(a) One-hand, one-motion door operation All doors shall have latching hardware to permit opening from the inside with a one-hand, one-motion operation without the use of a key or special tool. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all resident bedroom doors had latching hardware allowing the door to open from the inside with a one-hand, one-motion operation without the use of a key or special tool. Findings include: On 07/15/2024, the Department received a concern alleging resident bedrooms did not have door handles.	N 639		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110002	A. BUILDING: _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC HOUSE	202 N PATERSON ST MADISON, WI 53703

(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 639	Continued From page 12 On 08/15/2024, at approximately 1:30 PM, Surveyor toured the facility and observed a resident bedroom door that did not have a door handle. The bedroom was currently occupied by Resident 1 who stated s/he never had a door handle. On 08/15/2024, at approximately 1:45 PM, Surveyor interviewed Program Manager A stated s/he was aware of the missing bedroom door handle and was in the process of having it replaced. Program Manager A stated the bedroom door handle had been missing for several months.	N 639		