STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012225	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE WEST	209 W PARRY ST DODGEVILLE, WI 53533

(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 08/04/2023, The Bureau of Assisted Living, Southern Regional Office conducted 3 complaint investigation and an enforcement verification visit at Sunnyside West, a CBRF located in Dodgeville, WI. As a result of this survey, 5 violations of Chapter DHS 83 were issued. 1 violation from previous statement of deficiency (SOD) # 2ONI13 dated 03/16/2023 were corrected. 1 complaint was substantiated. Under statutory provisions of Wis. Stat. Ch50, $200 revisit fee is being assessed. Census: 6	{N 000}		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident remained from physical abuse.	N 348		

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

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N 348	Continued From page 1 On 07/25/2023, Case Manager E witnessed Caregiver C physically abuse Resident 1 during a transfer from Resident 1's wheelchair to the EZ stand. On 07/27/2023, Social Worker G and Agency RN H observed 2 small bruises in Resident 1's upper left arm. FINDINGS INCLUDE: On 07/27/2023, the department received a complaint concerning abuse of residents at facility. On 08/03/2023, Surveyors arrived at facility for a complaint investigation. INTERVIEW: On 08/03/2023 at 9:45 AM, Surveyor spoke with House Lead A concerning allegations of physical abuse. House Lead A stated that on 07/25/2023 during a care meeting with a managed care organization (MCO) the MCO case manager witnessed Caregiver C transferring Resident 1 in a rough manner. Caregiver C was roughly pushing and pulling Resident 1's arms out of the way of the EZ stand sling. House Lead A stated s/he observed that Resident 1 had developed 2 small bruises on his/her arms. On 08/03/2023 at 10:10 AM, Surveyor spoke with Licensee B. Licensee B acknowledged that on 07/25/2023 Caregiver C physically abused Resident 1. Licensee B stated s/he substantiated physical abuse during his/her investigation and that Caregiver C admitted to roughly grabbing/moving Resident 1's arms during transfer. Licensee B placed Caregiver C on suspension and reported the incident to the department. Licensee B stated s/he would email	N 348		

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N 348	Continued From page 2 Surveyor the investigation notes and report sent to the department. RECORD REVIEWS: On 08/03/2023, Surveyor reviewed Resident 1's individualized service plan (ISP) signed on 05/22/2023. Resident 1 is his/her own decision maker. Resident 1 was admitted to the facility on 07/29/2019. Resident 1 is diagnosed with a seizure disorder and is 1:1 when outside of his/her room. Resident 1 utilizes a wheelchair for mobility and requires 1:1 transfer into and out of the wheelchair. Resident 1's long term memory is intact but has difficulty with short term memory. On 08/03/2023, Surveyor reviewed the misconduct incident report licensee B sent to the department. The report stated the incident occurred on 07/25/2023. The report states the following, "[House Lead A] was meeting with [Case Manager D], observed [Caregiver C] rough handle [Resident 1] as [Caregiver C] was attempting to get the standing lift sling around [him/her]. [Case Manager D] told [Licensee B] that [s/he] saw [Caregiver C] grab roughly [Resident 1's] arms. [Case Manager D] was the only witness. There were no visible scars or bruises but [Resident 1] will get a re-check tomorrow (07/26,23 (sic.) and get back to us if [s/he] discovers any bruising... [Resident 1] is not expressive of [his/her] feelings, however, [Case Manager D] noticed fear on [Resident 1's] face. [Case Manager D] mentioned that it appeared that [Resident 1] was afraid of [Caregiver C], and would have preferred the younger Care Worker at that time...". Licensee B interviewed Caregiver C on 07/27/2023 and documented the following, " [Licensee B] explained the complaint, and [Caregiver C] told [Licensee B] yes, that	N 348		

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N 348	Continued From page 3	N 348		

happened, and took responsibility (sic.) I explained that I must ask [him/her] to not come to work until the state finished the investigation...".

On 08/03/2023, Surveyor reviewed Iowa County Department of Social Services documentation related to the physical abuse of Resident 1. Social Worker G documented the following, "7/27/2023...A report came on this date with concerns regarding elder abuse on [Resident 1]. The reported, [Case Manager D] ... stated that on 07/25/2023 [s/he] was at [Resident 1's] CBRF, in the office, talking to [House Lead A], when [s/he] observed a staff member, [Caregiver C] in the process of getting consumer from [his/her] wheelchair to an EZ stand. [Case Manager D] stated this staff member was aggressively whipping [Resident 1's] arms away from the wheelchair and then pulling on [his/her] arms aggressively to get [him/her] to stand up. [Case Manager D] stated [Resident 1] looked very uncomfortable. It was reported that [Caregiver C] had been reported for another incident earlier this year and was not supposed to be providing cares. [Resident 1] is mostly non verbal and not able to speak in full sentences... [Social Worker G] and [Agency RN H] met at [Facility Name] at approximately 12:15 pm. In talking with [Agency RN H], [s/he] stated that [s/he] had evaluated [Resident 1] for bruising on 7/25/23, on [his/her] left arm, but it seemed questionable and chose to evaluate again on 7/27/23. On this date writer and [Agency RN H] confirmed small bruising on top and under [Resident 1's] left arm. [Resident 1] was cooperative when being asked to look at [his/her] arms and did not appear to be in pain."

EXIT INTERVIEW:

On 08/03/2023 at 12:00 PM, Surveyor discussed

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N 348	Continued From page 4 the above concerns with House Lead A. House Lead A acknowledged that on 07/25/2023 Caregiver C was witnessed physically abusing Resident 1 during a transfer. CROSS REFERENCE N0381 DHS Chapter 83.35 (1)(a) Pre-Admission And Ongoing Assessments CROSS REFERENCE N0399 DHS Chapter 83.36 (2) Maintain Current Written Staffing Schedule	N 348		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. 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. This Rule is not met as evidenced by: Based record review and interview, the provider did not ensure each resident's needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in condition. On 07/25/2023, Case Manager D witnessed Caregiver C aggressively pushing and pulling Resident 1's arms during a transfer from	N 381		

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N 381	Continued From page 5	N 381		

Resident 1's wheelchair to the EZ stand. During Licensee B's investigation Caregiver C admitted to handling Resident 1's in a aggressive manner during the transfer. Resident 1 was not assessed by the facility staff or nurse after this incident.

FINDINGS INCLUDE:

On 07/27/2023, the department received a complaint concerning abuse of residents at facility.

On 08/03/2023, Surveyors arrived at facility for a complaint investigation.

On 08/03/2023, Surveyor reviewed Resident 1's individualized service plan (ISP) signed on 05/22/2023. Resident 1 is his/her own decision maker. Resident 1 was admitted to the facility on 07/29/2019. Resident 1 is diagnosed with a seizure disorder and is 1:1 when outside of his/her room. Resident 1 utilizes a wheelchair for mobility and requires 1:1 transfer into and out of the wheelchair. Resident 1's long term memory is intact but has difficulty with short term memory.

On 08/03/2023, Surveyor reviewed the misconduct incident report licensee B sent to the department. The report stated the incident occurred on 07/25/2023. The report states the following, "[House Lead A] was meeting with [Case Manager D], observed [Caregiver C] rough handle [Resident 1] as [Caregiver C] was attempting to get the standing lift sling around [him/her]. [Case Manager D] told [Licensee B] that [s/he] saw [Caregiver C] grab roughly [Resident 1's] arms. [Case Manager D] was the only witness. There were no visible scars or bruises but [Resident 1] with get a re-check tomorrow (07/26,23 (sic.) and get back to us is

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[s/he] discovers any bruising... [Resident 1] is not expressive of [his/her] feelings, however, [Case Manager D] noticed fear on [Resident 1's] face. [Case Manager D] mentioned that appeared that [Resident 1] was afraid of [Caregiver C], and would have preferred the younger Care Worker at that time...". Licensee B interviewed Caregiver C on 07/27/2023 and documented the following, " [Licensee B] explained the complaint, and [Caregiver C] told [Licensee B] yes, that happened, and took responsibility (sic.) I explained that I must ask [him/her] to not come to work until the state finished the investigation...".

On 08/03/2023, Surveyor reviewed Iowa County Department of Social Services documentation related to the physical abuse of Resident 1. Social Worker G documented the following, "7/27/2023...A report came on this date with concerns regarding elder abuse on [Resident 1]. The reported, [Case Manager D] ... stated that on 07/25/2023 [s/he] was at [Resident 1's] CBRF, in the office, talking to [House Lead A], when [s/he] observed a staff member, [Caregiver C] in the process of getting consumer from [his/her] wheelchair to an EZ stand. [Case Manager D] stated this staff member was aggressively whipping [Resident 1's] arms away from the wheelchair and then pulling on [his/her] arms aggressively to get [him/her] to stand up. [Case Manager D] stated [Resident 1] looked very uncomfortable. It was reported that [Caregiver C] had been reported for another incident earlier this year and was not supposed to be providing cares. [Resident 1] is mostly non verbal and not able to speak in full sentences... [Social Worker G] and [Agency RN H] met at [Facility Name] at approximately 12:15 pm. In talking with [Agency RN H], [s/he] stated that [s/he] had evaluated [Resident 1] for bruising on 7/25/23, on [his/her]

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N 381	Continued From page 7 left arm, but it seemed questionable and chose to evaluate again on 7/27/23. On this date writer and [Agency RN H] confirmed small bruising on top and under [Resident 1's] left arm. [Resident 1] was cooperative when being asked to look at [his/her] arms and did not appear to be in pain." On 08/03/2023 at 9:00 AM, Surveyor requested the assessment completed on Resident 1 after his/her change in condition on 07/25/2023 from House Lead A. House Lead A stated that the managed care organization completed an assessment but no one at the facility performed and documented an assessment on Resident 1 after his/her change in condition on 07/25/2023. CROSS REFERENCE N0348 DHS Chapter 83.32(3)(d) Rights of Residents: Freedom From Mistreatment CROSS REFERENCE N0381 DHS Chapter 83.35(1)(a) Pre-Admission And Ongoing Assessments	N 381		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the CBRF maintained a current schedule for staff the CBRF. The facility did not keep a current written schedule from 05/20/2023 to 07/30/2023.	N 399		

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N 399	Continued From page 8 FINDINGS INCLUDE: On 07/27/2023, the department received a complaint concerning abuse of residents at facility. On 08/03/2023, Surveyors arrived at facility for a complaint investigation. On 08/03/2023 at 11:30 AM, Surveyor requested the staff schedule from 05/20/2023 to 07/30/2023 from House Lead A. House Lead A printed out the staff schedule from 05/20/2023 to 07/30/2023. Surveyor asked if this was the current staff schedule that reflected when staff call in, no showed, left early, and/or swapped a shift. House Lead A stated that she did not have a staff schedule that was maintained to reflect staffing changes. House Lead A stated that s/he only had the original schedule but that s/he could look through staff time sheets and record if a staff member called in, no showed, left early and/or swapped a shift. On 08/03/2023 at 12:00 PM, Surveyor discussed the above concern with House Lead A. House Lead A acknowledged that the facility had not been maintaining a current staff schedule from 05/20/2023 to 07/30/2023. House Lead A stated s/he could use the staff timesheets to update the staff schedule and would be able to email the updated staff schedules to surveyors the following day. On 08/04/2023 at 1:28 PM, Surveyor received an email from House Lead A. House Lead A attached the staffing timesheets and original staff schedule to the email. House Lead A did not update the staff schedule from 05/20/2023 to	N 399		

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N 399	Continued From page 9 07/30/2023. CROSS REFERENCE N0348 DHS Chapter 83.32(3)(d) Rights of Residents: Freedom From Mistreatment	N 399		
{N 491}	83.44(2)(c) Interior floors, walls and ceilings. Every interior floor, wall and ceiling shall be clean and in good repair. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that facility walls and surfaces were clean and in good repair. There were several doors and walls observed with gouges, scuffs and marks from resident wheelchairs. This is a repeat violation from previous Statement of Deficiency (SOD) 2ONI11 dated 02/09/2021 and SOD 2ONI13 dated 03/16/2023. This is evidenced by: Findings include: On 08/03/2023, Surveyor toured the physical environment. OBSERVATIONS: There were scuffs and black marks on the walls in the hallway leading to resident bedrooms due to being struck by wheelchairs. The facility entrance/exit door was damaged with dents and scratches from being struck by wheelchairs.	{N 491}		

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{N 491}	Continued From page 10 The facility exit door at the rear of the facility was damaged with dents and scratches from being struck by wheelchairs. The bathroom door at the front of the facility used by residents was damaged at the bottom 1/4 of the door with scratches and scuff marks. The laundry room door was damaged with scratches and scuff marks. The door trim was damaged, broken and coming off the wall from being struck by wheelchairs. The shower room door was damaged. The Plexiglas kickplate was still broken from previous SOD 2ONI13 dated 03/16/2023. On 08/03/2023 at 1:00 PM, Surveyors discussed the above concern with House Lead A. House Lead A acknowledged that the facility needs some repairs and will contact maintenance to fix/replace concerns identified.	{N 491}		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that toxic chemicals were stored in a secure area. There were cleaning compounds stored in an unlocked laundry room. Facility is able to serve up to 8 individuals with	N 499		

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N 499	Continued From page 11 primary diagnoses that include but are not limited to: Developmentally Disabled, Physically Disabled and Traumatic Brain Injury. Findings include: On 08/03/2023, Surveyor observed the laundry room. The laundry room door was unlocked and propped open. The laundry room contained unlocked cabinets that were used to store disinfectant spray, furniture polish, upholstery cleaner and laundry detergent. On 08/03/2023 at 11:00 AM, Surveyor interviewed House Lead A. House Lead A stated that s/he did not know that chemicals needed to be secured in the laundry room. House Lead A stated that the lock on the laundry room door doesn't work and the door is unable to be locked at this time and acknowledged that the chemicals in the room were not secure.	N 499		