STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018914	A. BUILDING: _____ B. WING _____	C 09/16/2024

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EDENBROOK MEADOWS ASSISTED LIVING LLC	154 S PIONEER PARKWAY FOND DU LAC, WI 54935

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N 000	Initial Comments On 09/13/2024-09/16/2024, Surveyor conducted a complaint investigation and standard survey at Edenbrook Meadows Assisted Living LLC. Eight deficiencies were identified. The complaint was substantiated. Census: 19	N 000		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure complete background checks were conducted upon hired for 3 of 3 employees reviewed. The complete background check is to include the background information disclosure form (BID), the criminal history search form from the	N 219		

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

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N 219	Continued From page 1 department of justice (DOJ), and the information maintained by the department of safety and professional service regarding a person's credentials (IBIS). Findings include: On 09/13/2024, Surveyor reviewed employee records and identified the following: -Caregiver C was hired 02/01/2022. Caregiver C's record included his/her DOJ report and IBIS letter dated 03/15/2022. The record did not include a BID form due at time of hire. -Caregiver D was hired 05/31/2024. Caregiver D's record did not include a BID, DOJ report, or IBIS letter. -Caregiver E was hired 05/24/2024. Caregiver E's record did not include a BID, DOJ report, or IBIS letter. On 09/13/2024 at 1:28 PM, Surveyor interviewed Administrator A and Support Staff B. Administrator A reported s/he could not find evidence of Caregiver C's BID form, Caregiver D's and Caregiver E's complete background check being completed. Administrator A acknowledged an understanding of the concern and stated s/he would run updated complete background checks.	N 219		
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	N 220		

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N 220	Continued From page 2	N 220		

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 documentation was obtained from a physician, physician assistant, clinical nurse practitioner, or licensed registered nurse indicating 2 of 2 employees (Caregiver D and Caregiver E) reviewed was screened for clinically apparent communicable disease including tuberculosis (TB).

Findings include:

On 09/13/2024, Surveyor reviewed employee records and identified the following:

-Caregiver D was hired on 05/31/2024. His/her record did not include a baseline TB test or screened for communicable disease.

-Caregiver E was hired on 05/24/2024. His/her record did not include a baseline TB test or screened for communicable disease.

On 09/13/2024 at 1:28 PM, Surveyor interviewed Administrator A and Support Staff B. Administrator A reported s/he could not find evidence of TB tests or communicable disease

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N 220	Continued From page 3 screens for Caregiver D and Caregiver E. Administrator A stated s/he knows they were completed but noted his/her file keeping needs to get better. Administrator A acknowledged an understanding of the concern and stated both staff would get new testing completed.	N 220		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 employee (who required continuing education) completed at least 15 hours of continuing education in 2023. Findings include: On 09/13/2024, Surveyor reviewed employee files and identified the following: Caregiver C was hired 03/15/2022. Caregiver C's record did not include any hours of continuing education training for 2023.	N 277		

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N 277	Continued From page 4 On 09/13/2024 at 1:28 PM, Surveyor interviewed Administrator A and Support Staff B. Administrator A reported s/he could not find evidence of Caregiver C's continuing education for 2023. Administrator A acknowledged an understanding of the concern. Administrator A reported the provider was going to a web-based learning platform in the coming months and was hopeful this would help in ensuring staff complete required continuing education training.	N 277		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 4 individual service plans (ISP) reviewed were developed with	N 387		

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N 387	Continued From page 5	N 387		

involvement from the resident and resident's legal representative. Resident 1's, Resident 2's, Resident 3's, and Resident 4's ISP was not developed or signed by him/herself or his/her legal representative.

Findings include:

On 09/13/2024, Surveyor reviewed resident records and identified the following:

Resident 1 was admitted on 07/19/2021. Resident 1 was their own legal decision maker. Resident 1's most recent ISP with an unknown date did not contain a signature from him/herself.

Resident 2 was admitted on 03/25/2024. Resident 2 had a guardian. Resident 2's most recent ISP with an unknown date did not contain did not contain a signature from his/her legal representative.

Resident 3 was admitted on 08/20/2022. Resident 3 was their own legal decision maker. Resident 3's most recent ISP with an unknown date did not contain a signature from his/her legal representative.

Resident 4 was admitted on 01/04/2024. Resident 4 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 4's most recent ISP with an unknown date did not contain a signature from his/her legal representative.

On 09/13/2024 at 1:28 PM, Surveyor interviewed Administrator A and Support Staff B. Administrator A reported s/he did not have evidence resident care plans were reviewed and signed at care conferences. Administrator A

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N 387	Continued From page 6 stated s/he needs to get better having residents or their legal representative sign the ISPs. Surveyor noted review of resident progress notes showed legal representatives visiting often so signatures should have been obtained. Administrator A acknowledged an understanding of the concern and stated s/he will work on capturing required signatures going forward.	N 387		
N 481	83.43(1) Environment safe, clean, and comfortable 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. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the living environment was clean and homelike. Findings include: On 09/18/2024 at 8:29 AM-9:09 AM, Surveyor toured the facility and observed the following: Shower room: -Shower basin had what appeared to be dirt and hair buildup. -At least 6 circular black discoloration marks in the flooring. Pantry area: -Orangish circular splatter observed on a large portion of the ceiling above the refrigerators and	N 481		

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N 481	Continued From page 7	N 481		

freezers.
-The wall next to the time clock was covered in a black substance running down the walls.

Kitchen:
-The cabinet next to the stove did not close.
-The cabinet next to the sink was missing a hinge and hanging from the other.
-The PVC piping under the sink had a black tacky substance.
-The ceiling fan was covered in a thick layer of dust and cobwebs.
-The ceiling air duct had a thick layer of dust surrounding the circular vent.
-The countertop behind the kitchen sink had areas of a mold-like substance.
-The ceiling had many areas with a layer of what appeared to be dust and dirt buildup and orangish circular splatter.
-The island cabinetry had holes where previous electric boxes were cut out. The island was missing 2 -drawers.
-A sprinkler head was covered in dust.
-Inside cabinets next to the refrigerator, sticky to the touch and dust /dirt observed.
-Cabinets under the phone/radio station, had crates of onions and potatoes. Skin from onions was observed all over the bottom of the cabinet. Fly gnats were observed circling the produce.

On 09/13/2024 at 1:28 PM, Surveyor interviewed Administrator A and Support Staff B. Administrator A acknowledged an understanding of the environmental concerns in the kitchen and shower area. Administrator A reported s/he requested assistance from their corporate office in getting kitchen repaired but was told it was not in the budget. Administrator A reported s/he will address the cleaning concerns with staff.

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N 488	Continued From page 8	N 488		
N 488	83.44(1)(c) Clothes dryers enclosed and vented 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 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 2 of 2 clothes dryers utilized a vent that was made of rigid vent tubing. Findings include: On 09/13/2024 at 9:13 AM, Surveyor observed the provider's laundry room. Surveyor observed 2 of 2 clothes dryers vents were made of semi-rigid material. On 09/13/2024 at 1:28 PM, Surveyor interviewed Administrator A and Support Staff B. Administrator A acknowledged an understanding of the concern and stated s/he would follow up with their maintenance director get the dryer vents changed.	N 488		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an	N 525		

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N 525	Continued From page 9 evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a fire drill was conducted quarterly in 2023 and thus far into 2024. Findings include: On 09/13/2024, Surveyor reviewed safety records and identified the following: The provider did not have evidence of fire drills conducted quarterly in 2023 and the 1st and 2nd quarters of 2024. On 09/13/2024 at 1:28 PM, Surveyor interviewed Administrator A and Support Staff B. Administrator A reported fire drills were completed but due to poor organization of records evidence of drills could not be located. Administrator A stated s/he would work on coming up with a better system to retain records of fire drills completed.	N 525		
N 637	83.59(1)(g) Proper exit locations, sidewalks, driveways.	N 637		

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N 637	Continued From page 10 All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exits, sidewalks and driveways used for exiting shall be kept free of ice, snow, and obstructions. For facilities serving only ambulatory residents, the CBRF shall maintain a cleared pathway from all exterior doors to be used in an emergency to a public way or safe distance away from the building. For facilities serving semi-ambulatory and non-ambulatory residents, a CBRF shall maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2 primary exits from the building. All other required exits shall have at least a cleared pathway maintained to a public way or safe distance from the building. An exit door or walkway to a cleared driveway leading away from the CBRF also meets this requirement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 4 of 4 exits were unobstructed. Findings include: The provider is licensed to care up to 20 residents in the following client groups: physically disabled, irreversible dementia/Alzheimer's, terminally ill, and advanced age. On 05/24/2024, the Department received a complaint alleging the provider always blocked entryways with equipment.	N 637		

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N 637	Continued From page 11 On 09/13/2024, Surveyor toured the environment and observed the following: At 8:37 AM, Surveyor observed an exit near Resident 5's room. The door exited to the patio area. The door was obstructed with a sit to stand, hoyer lift, and an end table. At 9:13 AM, Surveyor observed an exit next to the laundry room obstructed with a vacuum and utility cart. The door exited to the parking lot. At 9:21 AM, Surveyor observed an exit to the back patio obstructed with a housekeeping cart and wheelchair. At 10:55 AM, Surveyor observed the back patio area. The patio was fenced in and the paved walkway leads to the left towards an approximately 6ft high gate. The exit was obstructed by 3 outdoor patio chairs. On 09/13/2024 at 1:28 PM, Surveyor interviewed Administrator A and Support Staff B. Administrator A acknowledged an understanding of the concern. Administrator A stated the facility lacked rooms for storage, so finding areas for equipment was challenging. Administrator A stated staff would be retrained on ensuring exits were unobstructed.	N 637		