STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012715	A. BUILDING: _____ B. WING _____	R-C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINCH HOUSE	5762 FINCH LN GREENDALE, WI 53129

(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 11/30/202, with information gathered through 12/08/2023, Surveyor conducted a verification visit and standard survey at Finch House. Fourteen deficiencies identified. Four of the 14 deficiencies were repeat deficiencies. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 5	{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 observation, record review, and interviews, the provider and its operation did not comply with all laws governing the Community Based Residential Facility (CBRF). The licensee did not ensure compliance with DHS 83 was achieved and maintained. As a result of this verification visit and standard survey, a total of 14 violations were issued. Four of the 14 violations were repeat deficiencies related to physical environment and administrator supervising daily operations. This is a repeat deficiency. See Statement of Deficiency (SOD) #44E013, dated 03/01/2023. Findings include:	{N 196}		

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

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{N 196}	Continued From page 1 The provider is licensed as a Class CNA (non-ambulatory) facility to care for 8 residents in the client groups irreversible dementia/Alzheimer's disease, advanced aged, intellectually disabled and emotionally disturbed/mental illness. On 11/30/2023 facility census was 5. On 11/30/2023, Surveyor reviewed Department records and identified the following: "On 09/05/2023, the Department issued a Notice and Order letter with Statement of Deficiency (SOD) 44E0113 dated 09/05/2023. The letter stated: "AS SOON AS PRACTICABLE AND WITHOUT DELAY, within 45 days of receipt of this notice, the licensee shall achieve and maintain substantial compliance with all requirements." Special orders included, "CONSULTANT REQUIRED... 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., EFFECTIVE IMMEDIATELY, the licensee shall ensure the provision of services to meet residents' physical and mental health needs. For medical and health monitoring related violations identified in Statement of Deficiency (SOD) 44E013, the licensee shall develop and implement corrective measures in consultation with a registered nurse (RN). The RN will have knowledge of assisted living regulations (e.g., Wis. Admin. Code ch. 83, Wis. Stat. ch. 50) and knowledge of the client groups served under medication management and administration, health monitoring and diabetes management. 2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., EFFECTIVE IMMEDIATELY, the licensee shall ensure interconnected heat detectors are installed in all required locations. The licensee's corrective actions will include the installation of any needed upgrades to the integrated smoke	{N 196}		

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{N 196}	Continued From page 2 and heat detection system in order to meet the requirements specified by Wis. Admin. Code § DHS 83.48(6). The licensee shall obtain approval from the department before installing a smoke and heat detection system." On 11/30/2023, Surveyor conducted an onsite verification visit of SOD 44E013 and a standard survey. Surveyor conducted interviews with administration and caregivers, made observations of the general environment and resident safety factors (fire extinguishers, integrated heat detector in laundry room and medication management). At approximately 11:00 AM, Surveyor observed the laundry area. The laundry area was located on the main level of the home between the kitchen and side exit. Surveyor observed a smoke detector on the ceiling instead of the required heat detector. At approximately 12:30 PM, Surveyor identified Resident 10 did not receive his/her noon dose of insulin because they had rin out of the medication and the pharmacy had not delivered more. Surveyor identified 4 deficiencies which were repeat deficiencies: 83.14(2)(a) Licensee Ensures Facility Complies With Laws 83.15(3)(a) Administrator Shall Supervise Daily Operations 83.32(3)(h) Rights of Residents: Receive Medications 83.48(6)(e) Integrated Heat Detector In Laundry Room On 11/30/2023 at approximately 2:15 PM, Director of Operations C stated s/he had started to work on some of these corrections but was not able to complete all of them yet. Director of Operations C stated s/he was working on them	{N 196}		

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{N 196}	Continued From page 3 with their consulting pharmacy nurse, caregivers, and maintenance staff. Director of Operations C confirmed Resident 10 missed his/her noon dose of insulin due to not receiving more from the pharmacy. Director of Operations C confirmed there was no heat detector in the laundry room. Director of Operations C explained the previous laundry room was in the basement, where there was currently a heat detector, and they had plans to move the laundry facilities to the basement so they would be compliant with the code.	{N 196}		
{N 214}	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on interview, record review, and observations, the administrator did not supervise the daily operation of the Community-Based Residential Facility (CBRF) including resident care and services, personnel, and physical plant. Director of Operations C did not provide the daily supervision necessary to ensure residents received proper care and treatment including	{N 214}		

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{N 214}	Continued From page 4 supervising personnel and ensuring a safe environment. This requirement is being cited for the fifth time. See Statements of Deficiency SOD 44E013 dated 03/01/2023, SOD 44E012, dated 09/14/2022, SOD 44E011, dated 04/25/2022, and SOD RG4M11, dated 04/11/2019. Findings include: On 11/30/2023 at 10:00 AM, Surveyor conducted an onsite verification visit of SOD 44E013 and a standard survey. Surveyor conducted interviews with administration, made observations of the general environment and resident safety factors (Resident 10's insulin medication management, home-like environment and integrated heat detector in laundry room). On 11/30/2023 at 1:30 PM, Director of Operations (DOO) C stated, "None of the staff had RN (registered nurse) delegation" until 11/24/2023 when s/he had an all staff training/meeting. DOO C reported Resident 10 moved in on 06/05/2023 and required insulin to be given 3 times a day. On 12/08/2023 at 8:25 AM, DOO C emailed Surveyor the following: "Sorry I missed this email yesterday. I did not receive a copy of the certifird [sic] for the application being sent. The licensee did also inform me of the intentions to have a new washer and dryer installed in the basement (original location years ago) where there is a heat detector already present and remove the laundry from the current placement upstairs. Essentially bringing the fire protection for that room back In [sic] line with the NFPA (National Fire Protection Association) guidelines. It's my understanding that will be completed by next week."	{N 214}		

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{N 214}	Continued From page 5 DOO C did not ensure regulatory compliance as evidenced by the following 14 deficiencies, including the 4 repeat deficiencies, that were identified during the verification visit. DOO C's level of supervision provided did not ensure correction of 4 repeat violations or compliance with the daily operations of the CBRF. The following 14 deficiencies were identified, including 4 repeat violations: 83.14(2)(a) Licensee Ensures Facility Complies With Laws (repeat deficiency) 83.15(3)(a) Administrator Shall Supervise Daily Operations (repeat deficiency) 83.17(1) Licensee Conduct Caregiver Background Check 83.17(2)(a) Employees Screened for Communicable Disease 83.32(3)(h) Rights of Residents: Receive Medications (repeat deficiency) 83.34(1) Limitations on Control of Resident Funds 83.37(1)(h) Scheduled Psychotropic Medications 83.37(2)(e) Other Administration Given or Delegated by RN 83.38(1)(c) Leisure Time Activities 83.42(3) Access to Resident Records 83.43(1) Environment Safe, Clean, and Comfortable 83.45(3) Toxic Substances 83.48(6)(e) Integrated Heat Detector In Laundry Room (repeat deficiency) 83.55(3) Bath and Toilet Areas: Hand Drying	{N 214}		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire,	N 219		

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N 219	Continued From page 6 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 a caregiver background check (CBC) was completed for 2 of 2 employees reviewed. Caregiver FF and Caregiver GG did not have a CBC on file. Findings include: According to The Wisconsin Caregiver Program Manual (P-00038), Wis. Stat. ch. 50, and Wis. Admin. Code ch. 12, a complete CBC, at minimum, consists of: 1) A completed DHS form F-82064, Background Information Disclosure (BID). 2) A response from the Department of Justice (DOJ). 3) A "Response to Caregiver Background Check" letter from the Department of Health Service, also referred to as the Integrated Background Information System (IBIS). On 11/30/2023, Surveyor reviewed employee records and identified the following:	N 219		

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N 219	Continued From page 7 Caregiver FF was hired on 06/15/2023. His/her record included a BID dated for 06/07/2023 but did not include a DOJ and IBIS. Caregiver GG was hired on 09/04/2023. His/her record included a BID dated for 09/02/2023 but did not include a DOJ and IBIS. On 12/05/2023 at approximately 4:30 PM, Director of Operations C sent Caregiver FF's and Caregiver GG's DOJ and IBIS. Surveyor reviewed documents and Caregiver FF's and Caregiver GG's DOJ and IBIS was dated 11/30/2023. On 12/05/2023, at approximately 4:32 PM, Surveyor interviewed Director of Operations C about the date on the DOJ and IBIS since it was the same date as the survey. Director of Operations stated s/he could not locate the DOJ and IBIS and neither could the staff member that helps upon hire. Since they did not have the documentation, they ran the background checks the same day as the survey because they were requested by Surveyor. Director of Operations C confirmed the DOJ and IBIS were not completed for Caregiver FF and Caregiver GG.	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 indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease	N 220		

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N 220	Continued From page 8 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 obtain from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating 1 of 2 employees reviewed had been screened for clinically apparent communicable disease including tuberculosis (TB). Caregiver FF did not have a screening or TB skin test within 90 days before the start of employment. Findings include: On 11/30/2023, Surveyor reviewed Caregiver FF's record. Caregiver FF was hired on 06/15/2023. Caregiver FF's record did not contain a communicable disease screening or TB test. On 12/05/2023 at approximately 2:30 PM, Director of Operations sent Caregiver FF's TB skin test and screening via email. Caregiver FF's TB test and communicable disease screening were completed on 05/16/2022. On 12/05/2023 at approximately 2:32 PM, Surveyor interviewed Director of Operations C. Director of Operations C stated s/he did not notice it was done in 2022 and not in 2023, within 90 days of hire for Caregiver FF. Director of Operations C stated s/he would ask to see if	N 220		

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N 220	Continued From page 9 there was a more recent one completed upon hire and provide the documentation to Surveyor. As of 12/07/2023 at 12:00 PM, Surveyor did not receive any additional information regarding Caregiver FF's TB skin test and screening.	N 220		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, 1 of 1 resident reviewed, did not receive his/her prescribed insulin in the dosage and intervals prescribed by a practitioner. Resident 10 missed one dose of insulin. This is a repeat deficiency. See Statement of Deficiency (SOD) #44E013, dated 03/01/2023. Findings include: On 11/30/2023, at approximately 12:30 PM, Surveyor interviewed Caregiver FF and asked if any residents received insulin. Caregiver FF stated Resident 10 was the only resident who received insulin. Surveyor asked Caregiver FF how often Resident 10 received insulin. Caregiver FF stated Resident 10 had two different kinds of insulin. One s/he only received once a week and the other s/he received three	{N 352}		

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{N 352}	Continued From page 10 times a day. On 11/30/2023, Surveyor reviewed Resident 10's record. Surveyor identified the following: - Resident 10 was admitted on 06/05/2023. - Resident 10's current medication list, dated 09/19/2023, identified, "Humalog Kwikpen (U-100) Insulin 100 unit/mL subcutaneous: Inject 7 unit(s) 3 times a day by subcutaneous route...Trulicity 1.5 mg/0.5 mL subcutaneous pen injector: Inject 1.5 mL every week by subcutaneous route." - Resident 10's November 2023 Medication Administration Record (MAR) stated, "Trulicity 1.5 mg/0.5mL subcutaneous pen injector: Inject 1.5 mL every week by subcutaneous route." Surveyor did not see two different kinds of insulin on MAR. Resident 10 had current order for Humalog Kwikpen (U-100) Insulin 100 unit/mL subcutaneous: Inject 7 unit(s) 3 times a day by subcutaneous route but facility was not documenting on MAR provided by the pharmacy. The provider had their own administration sheet documenting when Humalog Kwikpen (U-100) was being administered. - Resident 10's insulin administration documentation identified, "-Diabetes Flow Chart: Date, Time, Blood Sugar, Medication Dose Administered, Site, If Low Sugars Nourishment Given, Comments, Initials." There were three sheets and each were labeled with the following: "November 8 AM Novolog Insulin...November 12 PM Noon Novolog Insulin...November 4 PM Novolog Insulin." Surveyor observed Resident 10's Diabetes Flow Sheet not having documentation for 11/30/2023 at 12:00 PM. On 11/30/2023, at approximately 1:30 PM, Surveyor interviewed Caregiver FF and Director of Operations C. Caregiver FF confirmed	{N 352}		

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{N 352}	Continued From page 11 Resident 10 did not receive his/her Novolog insulin on 11/30/2023, noon dose, because they just ran out of the medication this morning at 8:00 AM when s/he administered Resident 10's Novolog. Caregiver FF stated s/he had tried calling pharmacy a few days before to let them know but no new Novolog had been delivered since the new pharmacy had taken over. Director of Operations C stated the new pharmacy took over on November 16th. Director of Operations C stated, "It's a good thing you were here today, otherwise I'm not sure if we would have caught this medication as early as we did." Director of Operations C contacted the pharmacy immediately to ensure Resident 10 did not miss another dose of his/her insulin on 11/30/2023.	{N 352}		
N 366	83.34(1) Limitations on control of resident funds. Authorization. Except for a resident in the custody of a government correctional agency, the CBRF may not obtain, hold, or spend a resident ' s funds without written authorization from the resident or the resident ' s legal representative. The resident or the resident ' s legal representative may limit or revoke authorization at any time by writing a statement that shall specify the effective date of the limitation or revocation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not get written authorization from 1 of 1 resident and/or resident's legal representative to obtain, hold or spend a resident's funds. Findings include:	N 366		

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N 366	Continued From page 12 On 11/30/2023, Surveyor reviewed Resident 11's record. Resident 11 was admitted to the facility on 05/15/2023. Resident 11 had an activated financial power of attorney . Resident 11's record identified the authorization form to obtain Resident 11's money was not completed. On 11/30/2023, at approximately 12:00 PM, Surveyor interviewed Director of Operations C about managing resident's money in the home. Director of Operations C stated Resident 11's family would send checks to the facility for them to cash and then they would give Resident 11 the cash but they did not monitor it or document what s/he spent it on. Director of Operations C stated s/he thought they filled out an authorization form to obtain Resident 11's money but was not sure. Director of Operations C reviewed Resident 11's record during the interview and found the authorization form in his/her record blank. Director of Operations C stated s/he knew this was a regulation but had not had time to fill out the form with Resident 11's power of attorney yet.	N 366		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication.	N 407		

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N 407	Continued From page 13 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident who had prescribed psychotropic medications was re-evaluated, at least quarterly, for the desired responses and possible side effects of each medication for 1 of 1 resident reviewed. Resident 11 received scheduled psychotropic medications and was not re-evaluated at least quarterly in 2023. Resident 11 was not evaluated in the 2nd and 3rd quarters of 2023. Findings include: On 12/07/2023, at 11:00 AM, Surveyor reviewed Resident 11's record. Resident 11 was admitted to the facility on 05/15/2023. Resident 11's medication administration record and written order identified Resident 11 was prescribed risperidone .5 milligram (mg) tablet 1 time daily. Resident 11's record indicated no psychotropic medication review since admission. Resident 11's Medication Administration Record (MAR), from 05/15/2023 through 11/30/2023, identified Resident 11 received risperidone .5 mg daily. On 12/07/2023, at 11:24 AM, Surveyor interviewed Director of Operations C. Director of Operations C reported s/he was not able to get their previous nurse consultant to complete psychotropic medication reviews for Quarter 2 and Quarter 3 of 2023. S/he reported moving forward the new pharmacy registered nurse would be completing the Quarter 4 reviews for 2023.	N 407		

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N 416	Continued From page 14	N 416		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure injectables medications were delegated by a Registered Nurse (RN) pursuant to the Nurse Practice Act [s. N 6.03(3)] and in accordance with accepted standards of practice for 2 of 2 unlicensed caregivers (Caregiver FF and Caregiver GG) reviewed. Findings include: Chapter N6.03(3) is the Standard of Practice for RN's and addresses the supervision and direction of delegated tasks. The RN may delegate a task based on the educational preparation and demonstrated abilities of the person supervised but must provide direction and assistance, and observe, monitor, and evaluate the effectiveness of the delegated tasks. On 11/30/2023, at 11:30 AM, Surveyor reviewed employee records and identified the following: Caregiver FF was hired on 06/15/2023. Caregiver FF's file did not contain evidence of receiving RN delegation for administering injectable medications.	N 416		

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N 416	Continued From page 15 Caregiver GG was hired on 09/04/2023. Caregiver GG's file did not contain evidence of receiving RN delegation for administering injectable medications. On 11/30/2023, at 12:00 PM, Surveyor reviewed Resident 10's record. Resident 10 was admitted 06/05/2023 with diagnoses including diabetes. Resident 10's medication administration record (MAR) indicated Resident 10 received Humalog Kwikpen (U-100) Insulin 100 unit/mL, 7 units subcutaneously, 3 times per day before breakfast, lunch and dinner daily. Resident 10's medication administration record (MAR) indicated Caregiver FF administered Resident 10's insulin 202 times from 06/15/2023 until 11/24/2023. Resident 10's MAR also indicated that Caregiver GG administered Resident 10's insulin 64 times from 09/04/2023 to 11/24/2023. On 11/30/2023, at 1:00 PM, Surveyor interviewed Director of Operations C. Director of Operations C reported s/he was aware of the code requirement which required employees to receive RN delegation for insulin injections. Director of Operations C confirmed Resident 10 received daily insulin three times a day, subcutaneously from employees since admission. Director of Operations C confirmed Caregiver FF and Caregiver GG did not receive RN delegation as required until 11/24/2023 from their consulting nurse. Surveyor asked if any previous delegation was completed from a different RN and Director of Operations C stated confirmed there was no RN delegation for any staff until 11/24/2023.	N 416		
N 427	83.38(1)(c) Leisure time activities. As appropriate, the CBRF shall teach residents	N 427		

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N 427	Continued From page 16 the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on observation and interview, the provider did not provide a daily activity program to meet the interests and capabilities of the residents for 5 of 5 residents. The provider did not have an activity program to offer any residents. Findings include: The facility is licensed to serve up to 8 residents with diagnoses including advanced age, irreversible dementia/Alzheimers, emotionally disturbed/mental illness and developmentally disabled. On 11/30/2023 from 10:00 AM to 2:30 PM, Surveyor observed no activities being completed. On 11/30/2023 at approximately 2:30 PM, Surveyor interviewed Director of Operations C. Director of Operations C reported there were no activities being completed. S/he stated, "I could tell you we try to and that we have an activity calendar we follow but that wouldn't be the truth."	N 427		

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N 427	Continued From page 17 Director of Operations C stated activities would be something s/he will be working on implementing on a daily basis.	N 427		
N 480	83.42(3) Access to resident records. The employee in charge on each work shift shall have a means to access resident records. This Rule is not met as evidenced by: Based on record review, observation and interview, the provider did not ensure the employee in charge on each work shift had a means to access resident records. Findings include: On 11/30/2023, Surveyor requested to review Resident 10's and 11's Individual Service Plans (ISP). Caregiver FF stated s/he was not sure where those were kept and s/he could show me the resident MAR's. Surveyor asked Caregiver FF if s/he had computer access to any of the resident records and s/he stated, "No, the facility has all paper charting." On 11/30/2023 at approximately 11:30 AM, Surveyor interviewed Director of Operations C. Director of Operations C stated s/he did not have the resident charts at the facility. S/he stated they took all the resident binders to the home office last week to update all of their ISP's. Surveyor asked Director of Operations C how staff in charge would be able to review resident records if they needed. Director of Operations C stated they would not be able to unless they contacted him/her and s/he brought it back to the facility. Director of Operations C stated it was his/her fault	N 480		

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N 480	Continued From page 18 they were not on site and that was his/her mistake.	N 480		
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 staff interview, the provider did not provide a living environment that is safe, clean, comfortable, and homelike for 5 of 5 residents. The facility was in need of cleaning and repairs. Surveyor observed the resident bedrooms needed repairs and the bathrooms needed cleaning and repairs. Findings include: On 11/30/2023 at approximately 10:05 AM, Surveyor toured the facility with Caregiver FF. Surveyor observed the following: -toxic substances not locked up (oven cleaner, multi purpose cleaner, bleach, Ajax soap, laundry detergent, sanitizer spray) -two pieces of tile missing on the sink counter in bathroom off of Resident 10's room -cabinet door on vanity in bathroom would not close and created approximately an inch gap -no toilet paper holder in the bathroom, 3 toilet paper rolls were sitting on sink counter -the flooring by the bathtub was peeling up,	N 481		

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N 481	Continued From page 19 approximately 1/2 inch -single use paper towel dispenser was empty -feces smeared on Resident 12's bedroom floor -Resident 11's closet door was broken, black scuffs on wall about 2-3 inches in length, an approximately 3-4 large 1 by 2 inch section of paint peeling off walls, dust-like substance all over wall vent -large 3 inch by 4 inch black scuffs against wall and 2-3 areas of paint missing (approx. 1-2 inches in diameter) in hallway by Resident 12's room -resident first and last names posted on their doors On 11/30/2023 at approximately 11:00 AM, Surveyor interviewed Director of Operations C. Director of Operations C reported s/he did notice some of these items when s/he was at the house last week. Director of Operations C reported s/he would contact maintenance about these items and make sure they were taken care of.	N 481		
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 cleaning compounds, polishes, insecticides, and toxic substances are labeled and stored in a secure area for 1 of 1 (laundry room) cleaning compound storage area. Findings include:	N 499		

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N 499	Continued From page 20 On 11/30/2023 at approximately 10:10 AM, Surveyor toured the facility with Caregiver FF. While touring the laundry room, Surveyor observed the cabinet above the washer opened without the use of a locking mechanism, with chemicals inside. Surveyor observed oven cleaner, multipurpose cleaner, bleach, Ajax soap and sanitizer spray. Surveyor also observed the unlocked closet in the laundry room with 4 jugs of laundry detergent. Surveyor interviewed Caregiver FF and asked if the cabinet and closet was kept open at all times. Caregiver FF stated the cabinet had been unlocked for a while and the closet was always left unlocked. On 11/30/2023 from 10:00 AM to 2:00 PM, Surveyor observed all residents moving freely throughout the facility and having access to the laundry room as it was in an open area off of the kitchen and back exit door. On 11/30/2023 at approximately 1:00 PM, Surveyor interviewed Director of Operations C about the toxic substances. Director of Operations C stated the cabinet had been like that for a while and s/he had put in a request for maintenance to come and fix it. S/he stated they noticed it when they were there the previous week and knew it was an issue then. Director of Operations C stated s/he would let their maintenance person know again about the lock needing to be fixed as soon as possible.	N 499		
{N 554}	83.48(6)(e) Integrated heat detector in laundry room. CBRFs shall have at least one heat detector integrated with the smoke detection system at all	{N 554}		

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{N 554}	Continued From page 21 of the following locations or in accordance with the heat detector manufacturer ' s specifications: Laundry room. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure the facility had at least one heat detector integrated with the smoke detection system located in the laundry room on the main level. This requirement is being cited for the fourth time. See SOD 44E011, dated 04/25/2022, SOD 44E012, dated 09/14/2022 and SOD 44E013, dated 03/01/2023. Findings include: On 11/30/2023 at approximately 10:00 AM, Surveyor reviewed the Notice and Order letter for provider, dated 09/05/2023. The letter read, "Pursuant to Wis. Stat. § 50.03(5g)(b)6., EFFECTIVE IMMEDIATELY, the licensee shall ensure interconnected heat detectors are installed in all required locations. The licensee's corrective actions will include the installation of any needed upgrades to the integrated smoke and heat detection system in order to meet the requirements specified by Wis. Admin. Code § DHS 83.48(6). The licensee shall obtain approval from the department before installing a smoke and heat detection system. WITHIN 30 DAYS of receipt of this notice, the licensee shall submit plans for review of any needed upgrades to the integrated smoke and heat detection system to the Office of Plan Review and Inspection (OPRI)." On 11/30/2023 at approximately 11:00 AM, Surveyor observed the laundry area. The laundry area was located on the main level of the home	{N 554}		

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{N 554}	Continued From page 22 between the kitchen and side exit. Surveyor observed a smoke detector on the ceiling instead of the required heat detector. On 11/30/2023 at approximately 11:10 AM, Surveyor interviewed Director of Operations (DOO) C who stated s/he was working on taking care of this and had filled out the application for OPRI on 10/15/2023 and gave it to Licensee E to send out with the check. Surveyor asked DOO C if there was a certified mail receipt or if s/he could confirm Licensee E sent out the information. On 12/08/2023 at 8:25 AM, DOO C emailed Surveyor the following: "Sorry I missed this email yesterday. I did not receive a copy of the certifird [sic] for the application being sent. The licensee did also inform me of the intentions to have a new washer and dryer installed in the basement (original location years ago) where there is a heat detector already present and remove the laundry from the current placement upstairs. Essentially bringing the fire protection for that room back In line with the NFPA (National Fire Protection Association) guidelines. It's my understanding that will be completed by next week."	{N 554}		
N 612	83.55(3) Bath and toilet areas: hand drying. Hand drying. All sink areas shall have dispensers for single use paper towels, cloth towel dispensing units that are enclosed for protection against being soiled or electric hand dryers. This requirement does not apply to sink areas located in toilet rooms accessed directly from a resident bedroom. This Rule is not met as evidenced by: Based on observation and interview, the provider	N 612		

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N 612	Continued From page 23 did not have dispensers with single use paper towels in 1 of 2 bathrooms observed. There were no paper towels in shared bathroom off of Resident 10's room. Findings include: On 11/30/2023 at approximately 10:10 AM, Surveyor toured the facility with Caregiver FF. Surveyor observed no single use paper towels in the dispenser in the shared bathroom by Resident 10's room. On 11/30/2023, at approximately 10:10 AM, Surveyor interviewed Caregiver FF about the paper towel dispenser. Caregiver FF stated there had not been single use paper towels in the dispenser for a while. On 11/30/2023 at approximately 2:00 PM, Surveyor interviewed Director of Operations C. Director of Operations C stated there should have been paper towels in the bathroom, and s/he would make sure there was and order more if necessary.	N 612		