| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0014823 | A. BUILDING: _____ B. WING _____ | C 07/14/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMFORT CARE 4 U 3 LLC | 2100 WESTCHESTER DRIVE FITCHBURG, WI 53711 |

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| M 000 | INITIAL COMMENTS<br><br>On 07/05/2023, with information gathered through 07/14/2023, Surveyor conducted a standard licensure survey and a complaint investigation at Comfort Care 4 U 3 LLC. Eleven deficiencies were identified.<br><br>Seven of the 11 deficiencies were repeat violations (see Statement of Deficiency (SOD) 3W1K11, SOD MWSV11 and SOD CMRY13).<br><br>Census: 3 | M 000 | | |
| M 232 | 88.04(2)(g)1 HEALTH SCREENING FOR STAFF<br><br>The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification.<br><br>This Rule is not met as evidenced by:<br>Based on record review and staff interview, the provider did not obtain documentation from a physician, a registered nurse or a physician's assistant, for 1 of 2 employee files reviewed (Caregiver F), indicating that the service provider had been screened for illness detrimental to residents, including tuberculosis (TB) within 90 days before the start of providing services. | M 232 | | |

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

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| M 232 | Continued From page 1<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) 3W1K11, dated 06/29/2021, and SOD MWSV11, dated 07/30/2019.<br><br>Findings include:<br><br>On 07/05/2023, Surveyor requested to review employee files including the health screen and screening for Tuberculosis for Caregiver F. Executive Assistant B provided the following documentation:<br><br>Caregiver F was hired on 09/22/2022. His/her file did not contain results from a TB screening until 02/27/2023 which was greater than 90 days since s/he had started providing services.<br><br>On 07/14/2023 at 8:43 AM, Surveyor emailed House Manager A and Executive Assistant B of the concern.<br><br>As of 07/14/2023 at 5:00 PM, Surveyor did not receive a response. | M 232 | | |
| M 246 | 88.04(5)(b) TRAINING-8 HOURS ANNUALLY<br><br>Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received. | M 246 | | |

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| M 246 | Continued From page 2<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the provider did not ensure that 2 of 2 service providers (Caregiver D) reviewed received at least 8 hours of continued education training related to health, safety, welfare, resident rights, and treatment of residents during 2021 and 2022.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) MWSV11, dated 07/30/2019.<br><br>Findings include:<br><br>On 07/05/2023, Surveyor requested Caregiver D's training record. Executive Assistant B provided the following documentation:<br><br>Caregiver D had a hire date of 10/08/2017.<br>Caregiver D's training record for 2021 consisted of trainings labeled 'Fire Safety Refresher III' (1.25 hours) and 'First Aid/Choking Refresher II' (1.5 hours). 2.75 hours completed out of the 8-hour annual required continuing education hours.<br>Caregiver D's training record for 2022 consisted of trainings 'Caring for Adults with Developmental Disabilities' (1 hour), 'Strategies for Managing Threatening Behaviors' (1 hour), 'Vital Measurements' (.75 hour), 'Medication Administration Skills Training' (1 hour), 'Caring for Residents with Mobility Needs' (.5 hour), and Recognizing, Preventing and Managing Pressure Ulcers' (.75 hour). 5 hours completed out of the 8-hour required annual continuing education hours.<br><br>On 07/13/2023 at 4:45 PM, Surveyor informed House Manager A of the concern. | M 246 | | |

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| M 322 | Continued From page 3 | M 322 | | |
| M 322 | 88.05(3)(m) 2 EXITS TO GRADE-BEDROOMS IN BASEMENT<br><br>No resident may regularly sleep in a basement bedroom or in a bedroom above the second floor of a single family dwelling unless there are 2 exits to the grade from that floor level.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure that there were 2 exits to grade from a basement dwelling. Resident 1's bedroom was in the basement and there was not a second exit to grade.<br><br>Findings include:<br><br>On 07/05/2023, at approximately 10:40 AM, Surveyor observed Resident 1's bedroom in the basement.<br><br>On 07/05/2023, at approximately 11:00 AM. Surveyor interviewed House Manager A. Surveyor asked where the second exit to grade was. House Manager A stated that Resident 1 could use the window in his/her bedroom.<br><br>The window in Resident 1's bedroom was observed to be blocked by his/her dresser. The dresser was not fixed to the wall which would create a fall hazard if Resident 1 attempted to exit the facility using the window.<br><br>Wis. State § SPS 321.03(6)(d) documented: "If the lowest point of clear opening is more than 46 inches above the floor, a permanent platform or fixture shall be installed such that a flat surface at least 20 inches wide and 9 inches deep is located | M 322 | | |

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| M 322 | Continued From page 4<br>no more than 46 inches directly below the clear opening. The topmost surface of the platform or fixture shall be no more than 24 inches above the floor."<br><br>On 07/05/2023, at approximately 11:30 AM, Surveyor discussed the above concern with House Manager A. House Manager A acknowledged that there must be at least 2 exits to grade from the basement level and that there should be a permanent platform or fixture in place to assist Resident 1 if his/her bedroom window was to be considered a secondary exit point. House Manager A stated Resident 1 was capable of exiting out of his/her bedroom window. | M 322 | | |
| M 348 | 88.05(4)(d)2.c SEMI-ANNUAL FIRE DRILLS<br><br>The licensee shall conduct semi-annual fire drills with all household members with written documentation of the date and the evacuation time for each drill maintained by the home.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not conduct semi-annual fire drills with all household members with written documentation of the date and evacuation time for each drill maintained by the home.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) 3W1K11 dated 06/29/2021.<br><br>Findings include:<br><br>The licensee can provide cares for up to 4 residents in the client groups: physically disabled, emotionally disturbed/mental illness, and | M 348 | | |

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| M 348 | Continued From page 5<br>developmentally disabled.<br><br>On 07/05/2023, Surveyor reviewed the provider's available semi-annual fire drills which documented that a fire drill had been completed on 09/08/2022, 11/03/2022, 11/21/2022 and 05/05/2023. Surveyor noted that each fire drill only included one resident and it was their initial assessment.<br><br>On 07/05/2023, at approximately 11:30 AM, Surveyor interviewed House Manager A. Surveyor asked if fire drills were completed where all residents who live in the home participate in the drill, not just the resident that required an initial evaluation. House Manager A did not have a response. | M 348 | | |
| M 380 | 88.06(2)(a) ADMISSION-HEALTH EXAM<br><br>Except as provided in subd. 2., the licensee shall ensure that a new resident of an adult family home receives a health examination by a physician to identify health problems and is screened for communicable disease, including tuberculosis. Screening for communicable disease may be provided by a physician, a registered nurse or a physician assistant. The health examination and screening shall take place within 90 days prior to admission to the home or within 7 days after admission.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not receive a health examination by a physician and have resident screened for | M 380 | | |

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| M 380 | Continued From page 6<br>communicable disease, including tuberculosis (TB), within 90 days prior to the admission to the home or within 7 days after admission for 1 of 2 resident records reviewed (Resident 1).<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) 3W1K11 dated 06/29/2021, and SOD MWSV11, dated 07/30/2019.<br><br>Findings include:<br><br>On 07/05/2023, Surveyor reviewed Resident 1's record.<br><br>Resident 1 was admitted to the facility on 05/03/2023.<br>Resident 1's record contained an undated and an unsigned "[Facility] Pre-Admission Health Assessment." Surveyor was unable to determine by this documentation if the resident had been seen by a physician.<br>Resident 1's TB test was completed on 06/05/2023.<br><br>On 07/14/2023 at 8:43 AM, Surveyor informed House Manager A and Executive B of the concern.<br><br>On 07/14/2023 at 1:14 PM, Executive Assistant B emailed Surveyor the "[Facility] Pre-Admission Health Assessment" that had been previously supplied and a medical exam "After Visit Summary," dated 06/05/2023. | M 380 | | |
| M 404 | 88.06(3)(a) INDIVIDUAL SERVICE PLAN & ASSESSMENT<br><br>The licensee shall ensure that a written assessment and individual | M 404 | | |

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| M 404 | Continued From page 7<br>service plan is completed and developed for each resident within 30 days after placement.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the licensee did not ensure 1 of 2 resident (Resident 1) reviewed had a written assessment and individual service plan (ISP) completed and developed within 30 days after placement.<br><br>Findings include:<br><br>On 07/05/2023, Surveyor requested Resident 1's record.<br><br>Resident 1 was admitted to the facility on 05/03/2023.<br><br>Resident 1's record contained a Behavior Support Plan (BSP), dated 10/25/2022.<br>Surveyor noted this was dated six months prior to Resident 1's admittance.<br><br>On 07/05/2023 at approximately 11:30 AM, Surveyor interviewed House Manager A. House Manager A stated staff utilized the BSP as the resident's current ISP.<br><br>On 07/14/2023 at 8:43 AM, Surveyor informed House Manager A and Executive B of the concern that the BSP was developed six months prior to Resident 1's admittance.<br><br>On 07/14/2023 at 1:14 PM, Executive Assistant B emailed Surveyor but did not provide additional clarification regarding Resident 1's ISP. | M 404 | | |

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| M 424 | Continued From page 8 | M 424 | | |
| M 424 | 88.06(3)(f) REVIEW OF ISP<br><br>The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 1 of 1 resident's (Resident 2) Individual Service Plans (ISP) were reviewed at least every 6 months.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) CMRY13 dated 01/05/2017.<br><br>Findings include:<br><br>On 07/05/2023, Surveyor reviewed Resident 2's record while onsite conducting a survey.<br><br>Resident 2 was admitted to the facility on 10/19/2022. | M 424 | | |

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| M 424 | Continued From page 9<br><br>Resident 2's available ISP was dated 10/25/2022. The ISP should have been reviewed in 04/2023.<br><br>On 07/05/2023 at approximately 11:30 AM, Surveyor interviewed House Manager A. House Manager A stated Surveyor was reviewing Resident 2's current ISP. | M 424 | | |
| M 448 | 88.07(2)(b)5 MONITORING HEALTH<br><br>Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not monitor Resident 2's health and inform Resident 2's guardian/resident representative when s/he experienced blood sugar (BS) levels over 200.<br><br>Findings include:<br><br>On 06/28/2023, the Department received a concern that alleged residents blood sugar levels were not being monitored.<br><br>On 07/05/2023, at approximately 3:10 PM, Surveyor interviewed Resident 2. Based on Resident 2's answers, s/he was unable to explain concerns regarding his/her BS levels.<br><br>On 07/05/2023, Surveyor reviewed Resident 2's record. | M 448 | | |

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| M 448 | Continued From page 10 | M 448 | | |

Resident 2 was admitted to the facility, 10/19/2022, with diagnoses including Type 2 diabetes, Noonan syndrome (genetic disorder), and intellectual disability and has an activated Power of Attorney (POC) C.

Resident 2's Individual Service Plan, dated 10/25/2022, documented:
"Medication Management: Staff administer [Resident 2's] medications."
"Medications: See attached MAR (medication administration record)"

Resident 2's May, June and July 2023 Medication Administration Records did not identify blood sugar level parameters.

Resident 2's "Blood Glucose Report," dated 04/03/2023 to 07/05/2023, documented:
04/12 - Wednesday - 7:00 PM 258 BS
04/17 - Monday - 8:37 AM 212 BS
04/19 - Wednesday - no documented BS
04/21 - Friday - 9:28 AM 232 BS - POA C should have been contacted
04/24 - Monday - 9:00 AM 215 BS
05/03 - Wednesday - 7:00 PM 269 BS
05/10 - Wednesday - 7:00 PM 269 BS - POA C should have been contacted
05/17 - Wednesday - 7:00 PM 320 BS - POA C should have been contacted
05/24 - Wednesday - 7:00 PM 339 BS - POA C should have been contacted
05/26 - Friday - 8:28 AM 201 BS
05/29 - Monday - no documented BS
05/31 - Wednesday - 7:00 PM 337 BS - POA C should have been contacted
06/05 - Monday - 2:17 PM 248 BS
06/07 - Wednesday - no documented BS
06/09 - Friday - 2:21 PM 288 BS - POA C should have been contacted

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| M 448 | Continued From page 11 | M 448 | | |

06/12 - Monday - 2:12 PM 370 BS - POA C should have been contacted
06/14 - Wednesday - 7:00 PM 419 BS - POA C should have been contacted
06/16 - Friday - no documented BS
06/19 - Monday - no documented BS
06/21 - Wednesday - 7:30 AM 250 BS, 5:00 PM 246 BS, 7:00 PM 238 BS - POA C should have been contacted
06/23 - Friday - 8:00 AM 292 BS
06/26 - Monday - 2:38 PM 265 BS
06/28 - Wednesday - 7:00 AM 216 BS
Surveyor noted the MAR documented that the presto strips were used on the dates the BS levels were not documented

On 07/05/2023, at approximately 1:55 PM, Surveyor interviewed Resident 2's managed care organization Care Manager (CM) E. CM E stated POA C had reported to him/her that POA C had reviewed the history on Resident 2's glucometer; the readings did not match what had been documented in Resident 2's record. POA C had informed CM E that there had been days when there were no readings on the glucometer, but the provider had documented readings in Resident 2's record. CM E explained that due to these discrepancies, Resident 2 is now on a continuous glucose monitoring system.

On 07/06/2023 at 4:55 PM, Executive Assistant B emailed Surveyor and stated Resident 2 was not an insulin dependent diabetic, so they are to follow the guidelines identified on the "Pharmacy Message Group," which is the software the provider utilized to manage resident records.

On Resident 2's "Pharmacy Message Group" documented:
"TEST BLOOD SUGAR MON/FRI (Monday and

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| M 448 | Continued From page 12 | M 448 | | |

Friday) BEFORE BREAKFAST (CALL [Power of Attorney (POA) C] IF BS>300 (BS is greater than 300) OR 3 TIMES>200 (BS over 200 3 times)); TEST BLOOD SUGAR WEDNESDAY BEFORE DINNER (CALL [POA C] IF BS>300 OR 3 TIMES>200"

Surveyor noted these guidelines were not documented in the ISP or on the MAR.

On 07/10/2023, Surveyor reviewed Resident 2's progress notes, on the dates when his/her BS levels were over 300, which documented:
05/17/2023 (BS 320) - "Overnight shift: [Resident 2] had a great night. [S/he] woke up around 6am and then staff helped [him/her] prepare. [s/he] ate [his/her] breakfast and took [his/her] meds before going to [his/her] day program. - 7:00 AM to 3:00 PM shift: [Resident 2] was fine during the shift. Assisted with all [his/her] morning cares, ate breakfast100%, given the morning meds, trimmed [his/her] finger nail and got picked up at 8;00am. - PM Shift: Came back from [his/her] day program at 4pm. [S/he] ate dinner, ate snacks, took [his/her] meds, used the toilet and watched tv in [his/her] room."
05/24/2023 (BS 339) - "Overnight shift: [Resident 2] went to bed at 10pm for the night and turned off [his/her] light and tv. [s/he] woke up at 430am and turned on [his/her] tv. [s/he] came out of [his/her] room at 7am to start [his/her] morning routine. - 7:00 AM to 3:00 PM shift: [Resident 2] was in the kitchen when staff arrived this morning. Assisted with all [his/her] care , medication and breakfast, shaved and got picked up 8:00am. - PM Shift: [Resident 2] ate supper, took [his/her] meds, chat with staff and watched tv."
05/31/2023 (BS 337) - "Overnight shift: [Resident 2] slept well throughout the night. [S/he] woke up

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to use the toilet as well. - 7:00 AM to 3:00 PM shift: The manager called this morning and mentioned to staff that [Resident 2] needs to use a wheelchair till [s/he] see the specialist for [his/her] leg. The driver came to pick [his/her] up and refused to take [his/her] with [his/her] with the wheelchair. Staff let the manager and the coordinator from the day program [sic] about the situation. The coordinator mentioned to staff to speak to [name] if [s/he] needs to change [his/her] transportation till [s/he] see the specialist and suggested to keep [his/her] home for today. [Resident 2] assisted with all [his/her] care, ate breakfast, lunch and snack 100%.`- PM Shift: [Resident 2] ate supper, took [his/her] meds, watched tv and chat with staff."
06/12/2023 (BS 370) - "7:00 AM to 3:00 PM shift: [Resident 2] was great during the morning and [s/he] ate breakfast and took [his/her] morning medication then [s/he] got picked up at 8:30am no issue. - PM Shift: [Resident 2] ate supper, took [his/her] meds and watched tv in [his/her] room."
06/14/2023 (BS 419) - "Overnight shift: [Resident 2] slept well throughout the night and used the toilet once. When [s/he] woke up in the morning [s/he] told staff [s/he] was not feeling well due to [his/her] throat so [s/he] did not end up going to [his/her] day program. - 7:00 AM to 3:00 PM shift: [Resident 2] not feeling well today, [s/he] didn't go to work [s/he] told staff that [s/he] is not feeling well and staff called in to cancel bus and also called [his/her] day program coordinator after [s/he] ate [his/her] breakfast and took [his/her] medication then [s/he] went [his/her] room and [s/he] watched tv and [s/he] ate [his/her] lunch and [s/he] also did some coloring and took a nap. - PM Shift: [Resident 2] ate dinner, staff assisted [him/her] with [his/her] meds and [s/he] later watched tv."

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| M 448 | Continued From page 14<br><br>Surveyor noted there was no documentation regarding Resident 2's BS level being over 300 and POA C was not documented as being contacted.<br><br>On 07/10/2023 at 11:52 AM, Surveyor emailed House Manager A and Executive Assistant B requesting documented communication that notified POA C when the parameters outlined in the "Pharmacy Message Group" had been met.<br><br>On 07/11/2023 at 3:29 PM, Executive Assistant B responded with a menu that POA C had created that documented, "[POA C] needs to be contacted with BS < (less than) 100/ > (greater than) 200."<br><br>As of 07/13/2023 at 5:00 PM, Surveyor did not receive any additional documentation. | M 448 | | |
| M 464 | 88.07(3)(d) MEDICATION- WRITTEN ORDER<br><br>Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, prior to dispensing or administering medications to a | M 464 | | |

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resident, the facility did not obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances, and in what dosage the medication is to be administered for 1 of 2 residents (Resident 1).

Findings include:

On 07/05/2023, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the home, 05/03/2023, with diagnoses including autism and metabolic syndrome (a group of conditions that together raise your risk of coronary heart disease, diabetes, stroke, and other serious health problems).

Resident 1's "Pre-Admission Health Assessment" documented that the individual was not capable of administering his/her own medications.

Resident 1's record did not include an individual service plan that outlined who would be administering his/her medications.

Resident 1's record contained a health cooperative documentation, dated 06/06/2023, that documented: "Staff at [his/her] group home should assist with administration of [his/her] prescribed medications as needed."

Resident 1's record contained a medical "After Visit Summary," dated 06/05/2023, which documented Resident 1's medications: Diazepam (anxiety medication), Divalproex (seizure medication), Fluoxetine (mental health medication), Propranolol (beta blocker),

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| M 464 | Continued From page 16<br>Risperidone (antipsychotic medication).<br><br>On 07/05/2023, at approximately 11:30 AM, Surveyor interviewed House Manager A. House Manager A stated staff have always administered Resident 1's medications. | M 464 | | |
| M 474 | 88.07(4)(c) FOOD PREPARED AND STORED SANITARY WAY<br><br>Food shall be prepared and stored in a sanitary manner.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not store food under sanitary conditions. Surveyor found food items in the refrigerator and pantry that were not properly sealed to avoid contamination and food items in the freezer that were not properly sealed to avoid freezer burn. The provider did not implement a system to identify when opened food was to be discarded for the prevention of food borne illnesses.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) CMRY13 dated 01/05/2017.<br><br>Findings include:<br><br>The licensee can provide cares for up to 4 residents in the client groups: physically disabled, emotionally disturbed/mental illness, and developmentally disabled.<br><br>On 07/05/2023, at approximately 10:30 AM, Surveyor toured the kitchen and observed the | M 474 | | |

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| M 474 | Continued From page 17<br>following:<br><br>Refrigerator:<br>-A 16 ounce container of sour cream with a 'Best By' date of 06/05/2023<br>-A plastic sandwich bag with what appeared to be slices of processed sandwich meat<br>-An opened bag of sandwich skinnys with a sticker date of 05/12/2023<br>-A 18 ounce bag of blended salad mix with a 'Use By' date of 06/26/2023<br>-A 16 ounce opened jar of alfredo sauce that was not dated.<br>-A 15 ounce opened jar of con queso cheese dip with a 'Best By' date of 05/04/2023<br>-An opened gallon of orange juice that was not dated and had a 'Best By' date of 07/04/2023<br>-A 32 ounce container of macaroni salad that was not dated and had a 'Use By' date of 06/28/2023<br>-A 16 ounce container of potato salad that was not dated<br>-A 4 ounce package of hard salami that had a 'Use By' date of 03/01/2023<br>-A 16 ounce package of oatmeal cookie dough that had a 'Use By' date of 04/05/2023<br>-A plastic container with a red cover contained a spaghetti based leftover food inside that was not labeled or dated<br>-A white glass bowl with green trim contained a spaghetti based leftover food inside that was not labeled or dated<br>-A plastic grocery bag contained a take out cardboard container that was not labeled or dated<br>-A white rectangular container with a snap on lid that contained leftover salad that was not dated<br>-A black plastic take out container with a clear lid that contained a leftover food that was not labeled or dated<br>-A small plastic bowl with a green lid that contained a yellow colored food was not labeled | M 474 | | |

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or dated
-A 46 fluid ounce opened bottle of grape juice that was not dated
-A 6 ounce opened package of sharp cheddar cheese slices were not sealed
-A chunk of white cheese with colorful speckles was half wrapped in a napkin
-An 8 ounce opened chunk of pepper jack cheese was not sealed
-A plastic bag containing what appeared to be 3 thawed brats were not labeled or dated
-A banana cut in half sitting on top of a pickle jar that was not sealed or dated

Freezer:
-(2) pancakes sitting directly on the freezer door that were not sealed

Pantry:
-A 16 ounce open package of long noodle spaghetti
-A 16 ounce open package of penne rigate noodles
-A 5 pound bag of white corn meal that was not sealed

Surveyor observed a bowl of fruit on the countertop that contained an orange that had approximately a 1 inch black circular ring on the bottom of it, which appeared to be spoilage, and an apple that contained an approximately 2 inch black circular brown ring on the side of it, which appeared to be bruising/spoilage.

"Time/temperature control for safety (TCS) guidelines indicate food prepared in a food establishment and held longer than a 24 hour period shall be marked to indicate the date or day by which the food is to be consumed on the premises, sold, or discarded when held at a

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| M 474 | Continued From page 19<br><br>temperature of 5°C (41°F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Refrigerated, RTE (ready-to-eat)/TCS food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed or discarded." (US Food and Drug Administration (FDA) Food Code, 2022, Section 3-501.17)<br><br>"Ready-to-eat TCS food (foods that need time and temperature control for safety) can be stored for only seven days if it is held at 41 degrees Fahrenheit or lower. The count begins on the day the food was prepared or a commercial container was open. TCS foods includes milk and dairy products, eggs, meat (beef, pork, and lamb), poultry, fish, shellfish and crustaceans, baked potatoes, tofu or other soy protein, sprouts and sprout seeds, sliced melons, cut tomatoes, cut leafy greens, untreated garlic-and-oil mixtures, and cooked rice, beans, and vegetables." (ServSafe Coursebook, 7th edition, 2017, p. 1-7, p. 1-8, and p. 7-3)<br><br>On 07/05/2023, at approximately 11:30 AM, Surveyor interviewed House Manager A. House Manager A stated s/he would discuss the concerns with staff. | M 474 | | |
| M 570 | 88.10(3)(l) Safe Physical Environment<br><br>Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The | M 570 | | |

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adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not safeguard residents from environmental hazards.
The provider's water temperature exceeded 115° Fahrenheit (F) at resident bathroom sink faucet.
The wooden handicapped ramp contained handrails that were not secure.

This is a repeat deficiency. See Statement of Deficiency (SOD) 3W1K11 dated 06/29/2021.

Findings include:

The licensee can provide cares for up to 4 residents in the client groups: physically disabled, emotionally disturbed/mental illness, and developmentally disabled.

Example 1: Water Temperature

On 07/05/2023, at approximately 10:30 AM, Surveyor toured the environment. Surveyor tested the hot water temperatures at the resident's bathroom sink faucet which temped at 126.5 °F.

"Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that

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prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding; e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability." (Source: Publication DHS P-01942 - 08/2017).

On 07/05/2023, at approximately 11:30 AM, Surveyor interviewed House Manager A. House Manager A stated s/he would inform his/her staff to adjust the hot water heater.

Example 2: Handrail

On 07/05/2023, at approximately 10:15 AM, Surveyor arrived at the home. As Surveyor utilized the handrail of the handicap ramp to walk to the entrance of the home, Surveyor noticed the handrail swayed back and forth.

On 07/05/2023, at approximately 11:30 AM, Surveyor interviewed House Manager A. Surveyor stated that the handrail to the handicap ramp was not secure when first walking onto the ramp. House Manager A made a note on his/her tablet of paper and nodded his/her head.