STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010954	A. BUILDING: _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POTTERS COUNTRY HOME	N3430 STATE RD 25 MENOMONIE, WI 54751

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N 000	Initial Comments On 04/24/2024, Surveyor conducted a complaint investigation and abbreviated licensure survey at Potter's Country Home. The complaint was unsubstantiated. Six violations were identified. Census: 15	N 000		
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 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 2 of 2 staff (Caregiver B and Caregiver C) were screened for communicable disease, including tuberculosis (TB), according to the Center for Disease Control and Prevention (CDC) standards. Findings include:	N 220		

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

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N 220	Continued From page 1 On 04/24/2024, Surveyor reviewed 2 employee records. Caregiver B was hired on 12/28/2022. Caregiver B's file included a 1-step TB skin test (TST) completed on 01/05/2023. The record did not include evidence Caregiver B was screened for other communicable diseases. Caregiver C was hired on 05/17/2021. Caregiver C's file included a 1-step TST completed on 05/24/2021 and ready by a certified medical assistant (CMA). The record did not include evidence Caregiver B was screened for other communicable diseases. At 12:55 PM, Surveyor interviewed Administrator A. Administrator A stated new employees were expected to go to the local public health office to be screened for general illness and tested for TB by their nurses. Administrator A reviewed Caregiver B's and Caregiver C's record and concluded public health's form did not include screening for communicable disease other than TB. Administrator A stated this was an oversight on his/her part. Administrator A was unaware Caregiver C's TB test was completed by a CMA. Administrator A stated s/he would educate the public health office on what s/he needed to complete new employee health screens.	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,	N 277		

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N 277	Continued From page 2 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 2 of 2 staff sampled (Caregiver B and Caregiver C) completed continuing education requirements. Caregiver B did not complete these training requirements in 2023 and Caregiver C did not complete training requirements in 2022 or 2023. Findings include: On 04/24/2023, Surveyor reviewed 2 employee records. Caregiver B was hired on 12/28/2022. Caregiver B's training record did not include evidence s/he completed training on the prevention and reporting of abuse, neglect, and misappropriation in 2023. Caregiver C was hired on 05/17/2021. Caregiver C's training record did not include documentation indicating how many hours of continuing education s/he completed in 2022; the documented training did not include evidence s/he completed training on standard precautions or medications in 2022. Caregiver C's 2023 training record did not include evidence s/he completed training on the prevention and reporting of abuse, neglect, and misappropriation	N 277		

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N 277	Continued From page 3 in 2023. At 12:30 PM, Surveyor interviewed Administrator A. Administrator A stated s/he utilized multiple formats for continuing education. In 2022 and 2023 s/he utilized a combination of self-paced training resources. Surveyor reviewed the training materials s/he used each year and did not find evidence of standard precautions or medication training in 2022 or abuse/neglect/misappropriation training in 2023. Administrator A reviewed the training materials and confirmed those topics were missed. Administrator A stated this was an oversight when forming the continuing education plans for these years. Surveyor asked how many hours Caregiver C completed in 2022. Administrator A reviewed his/her training certificates and stated Administrator A forgot to put the hours attributed to Caregiver C's training on his/her certificates. Administrator A estimated Caregiver C completed 16 hours of training in 2022.	N 277		
N 287	83.27(2)(a) Admissions compatible with the license class A CBRF may not admit or retain any of the following persons: A person who has an ambulatory or cognitive status that is not compatible with the license classification under s. DHS 83.04(2). This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider retained a non-ambulatory resident (Resident 1) that was not compatible with the provider's semi-ambulatory license.	N 287		

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N 287	Continued From page 4 Findings include: The provider has a class A semi-ambulatory (AS) license to care for 15 residents in the client groups advanced aged and developmentally disabled. A class A semi-ambulatory (AS) license serves only residents who are ambulatory or semi-ambulatory and who are mentally and physically capable of responding to a fire alarm by exiting the facility without any help or verbal or physical prompting. "Semi-ambulatory" means a person is able to walk with difficulty or only with the assistance of an aid such as crutches, cane, or a walker, according to DHS 83.02(51). DHS 83.02(34) states "non-ambulatory" means a person who is unable to walk but who may be mobile with the help of a wheelchair or other mobility devices. On 04/24/2024 at approximately 10:30 AM, Surveyor interviewed Administrator A. Administrator A stated Resident 1 used a wheelchair for mobility. At approximately noon, Surveyor observed Resident 1 at the dining table in his/her wheelchair. Surveyor reviewed Resident 1's record. Resident 1 moved to the facility on 08/20/2018. According to evacuation assessments, Resident 1 began using his/her wheelchair in 2021. At approximately 1:00 PM, Surveyor interviewed Administrator A. Administrator A stated Resident 1 was fully independent with all cares, transfers, and mobility. S/he stated Resident 1 used a	N 287		

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N 287	Continued From page 5 walker when s/he was first admitted. For a while, Resident 1 would use his/her walker or wheelchair, and s/he began exclusively using his/her wheelchair about 12 months ago. Administrator A stated, "I was under the impression semi-ambulatory meant able to move independently with assistive device."	N 287		
N 417	83.37(3)(a) Medication storage: original containers. Original containers. The CBRF shall keep medications in the original containers and not transfer medications to another container, unless the CBRF complies with all of the following: 1. Transfer of medications from the original container to another container shall be done by a practitioner, registered nurse, or pharmacist. Transfer of medication to another container may be delegated to other personnel by a practitioner, registered nurse or pharmacist. 2. If a medication is administered by CBRF employees and the medication is transferred from the original container by a registered nurse, or practitioner or other personnel who were delegated the task, the CBRF shall have a legible label on the new container that includes, at a minimum, the resident ' s name, medication name, dose and instructions for use. The CBRF shall maintain the original pharmacy container until the transferred medication is gone. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medications were stored in their original pharmacy packaging. Findings include:	N 417		

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N 417	Continued From page 6 On 04/24/2024 at approximately 11:45 AM, Surveyor observed the providers medication storage system with Caregiver C. Caregiver C opened the cabinet and explained s/he already had the noon medications prepped. Surveyor observed 3 plastic cups with tablets in them. The cups were not labeled with anything but the residents' first names. Caregiver C stated, "I set up the meds (medications) ahead of time." Caregiver C explained it was his/her practice to prep the medications at the beginning of his/her shift for the morning medication pass and s/he prepped the noon medications when s/he had a free moment after breakfast.	N 417		
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 and toxic chemicals were securely stored. Findings include: The provider is licensed to care for 15 advanced aged residents. On 04/24/2024 at 10:38 AM, during a tour with Administrator A, Surveyor observed the cleaning closet door and the laundry room door to be unlocked. Surveyor observed a gallon of bleach on an open shelf in the laundry room. The cleaning closet had a variety of cleaning	N 499		

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N 499	Continued From page 7 compounds, including bleach. The hazard statement on the bleach bottles included, "Causes severe skin burns and eye damage. Causes serious eye damage" These doors remained unlocked throughout the survey. At approximately 2:00 PM, Surveyor interviewed Administrator A. Administrator A stated the cleaning closet door remained unlocked during daytime hours. Administrator A said the laundry room always stayed open so residents could utilize the facilities, but the cleaning closet was locked during the evening hours. Administrator A was not aware cleaning compounds and toxic substances needed to be securely stored. S/he stated s/he would implement a system to ensure the bleach in the laundry room was removed and the cleaning closet was locked at all times.	N 499		
N 532	83.47(4)(b) Fire extinguishers: locations. A fire extinguisher shall be mounted on a wall or a post or in an unlocked wall cabinet used exclusively for that purpose. Fire extinguishers shall be clearly visible. The route to the fire extinguisher shall be unobstructed and the top of the fire extinguisher shall not be over 5 feet high. The extinguisher shall not be tied down, locked in a cabinet or placed in a closet or on the floor. Fire extinguishers on upper floors shall be located at the top of each stairway. Extinguishers shall be located so the travel distance between extinguishers does not exceed 75 feet. The extinguisher on the kitchen floor level shall be mounted in or near the kitchen. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the fire extinguisher on the first	N 532		

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N 532	Continued From page 8 floor was clearly visible when it was stored in an unmarked cabinet. Findings include: On 04/24/2024 at approximately 10:45 AM, Surveyor toured the facility with Administrator A. Surveyor asked where the fire extinguisher was on the main level. Administrator A opened a wooden cabinet near the kitchen to show Surveyor the fire extinguisher. The cabinet had a solid wood (not transparent) door and it did not have signage indicating the fire extinguisher was stored in it. At approximately 2:00 PM, Surveyor reviewed the survey findings with Administrator A. Administrator A stated the fire extinguisher had always been stored in the observed cabinet but the cabinet door used to have a large sticker on it indicating a fire extinguisher could be found inside. Administrator A stated the sticker was removed in 2022 when s/he remodeled the kitchen.	N 532		