STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011989	A. BUILDING: _____ B. WING _____	R-C 10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELANEY HOME	5342 3RD AVE PITTSVILLE, WI 54466

(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 10/03/2023, Surveyor conducted a verification visit at Delaney Home, a Community-Based Residential Facility (CBRF) in Pittsville, WI. Two deficiencies identified. One new deficiency and one repeat deficiency from SOD #6FEQ11 dated 07/11/2022. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assess. Census: 8	{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 documentation was obtained from a physician, physician assistant, clinical nurse practitioner or licensed registered nurse indicating 2 of 2 employees reviewed were screened for clinically apparent communicable	{N 220}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011989	A. BUILDING: _____ B. WING _____	R-C 10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELANEY HOME	5342 3RD AVE PITTSVILLE, WI 54466

(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 220}	Continued From page 1 disease, including tuberculosis (TB) within 90 days before the start of employment. Caregiver F and Caregiver G did not have documentation that they were screened for communicable diseases including tuberculosis within 90 days before the start of employment. This is a repeat deficiency, see Statement of Deficiency (SOD) # 6FEQ11 dated 07/11/2022. Findings include: On 10/03/2023, Surveyor reviewed employee files for Caregiver F and Caregiver G. Caregiver F's employee file indicated the caregiver was hired on 03/07/2023. The file contained no documentation Caregiver F was screened for communicable diseases within 90 days before the start of employment. Caregiver G's employee file indicated the caregiver was hired on 06/04/2023. The file contained no documentation Caregiver G was screened for communicable diseases within 90 days before the start of employment. On 10/03/2023 at 1:50 p.m., Surveyor interviewed Licensee A regarding the absence of communicable disease screenings for the reviewed caregivers. Licensee A acknowledged the employee files for Caregivers F and G did not have documentation of a screening for communicable disease including TB.	{N 220}		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is	N 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011989	A. BUILDING: _____ B. WING _____	R-C 10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELANEY HOME	5342 3RD AVE PITTSVILLE, WI 54466

(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 406	Continued From page 2 discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on observation and interview, the provider did not store medications that could not be returned to the pharmacy separate from other medication in current use within the facility and stored in a locked area, with access limited to the administrator or designee. Findings include: On 10/03/2023, Surveyor conducted a verification visit. As part of the verification visit, Surveyor observed the facility's medication storage with Caregiver H. The facility had all residents' medications in the cabinet in the kitchen. Each	N 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011989	A. BUILDING: _____ B. WING _____	R-C 10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELANEY HOME	5342 3RD AVE PITTSVILLE, WI 54466

(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 406	Continued From page 3	N 406		

resident had their own bin with their medications in it with strip packaging.

On 10/03/2023 at approximately 1:30 p.m., Surveyor asked Caregiver H where they store medications that need to be destroyed or have been discontinued. Caregiver H stated they keep them in the kitchen cabinets with the other medications. Caregiver H stated Resident 4 was the only resident who had medications that needed to be destroyed because his/her medications were discontinued. Caregiver H stated the pharmacy kept sending the medications in packets. Caregiver H stated they had to pull out that pill every time they pass the pack of medications and then they put it in the Ziploc bag for the administrator to destroy. Surveyor asked to review the discontinued medications.

Surveyor observed approximately 30 lose pills in a Ziploc bag with empty strip packaging for Resident 4. There were about 14 pills still in strip packaging. The dates on some of the packages were 08/07/2023, 08/23/2023, 09/25/20203, and 09/27/2023. Surveyor asked Caregiver H how long Resident 4 had this medication discontinued for and that they had to pull out of the packaging daily. Caregiver H stated, "For a while." Surveyor asked if it had been more than 30 days and Caregiver H said yes, at least a few months.

Surveyor requested to review Resident 4's current Medication Administration Record (MAR). Resident 4's October 2023 MAR stated, "Vitamin D-3 2,000 Units: Give 1 tablet by mouth daily," discontinued with no date.

Surveyor reviewed above information with Administrator A. Administrator A acknowledged

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011989	A. BUILDING: _____ B. WING _____	R-C 10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELANEY HOME	5342 3RD AVE PITTSVILLE, WI 54466

(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 406	Continued From page 4 discontinued medications needed to be separate from current resident medications.	N 406		