STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018175	A. BUILDING: _____ B. WING _____	R-C 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF MADISON	734 MESTA LANE MADISON, WI 53704

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{N 000}	Initial Comments On 06/20/2024, Surveyors conducted a complaint investigation and verification visit at Traditions of Madison. Three deficiencies were identified. Two of 3 deficiencies were repeat violations (see statement of deficiency (SOD) #6XI914, dated 02/08/2024 and SOD #6XI912, dated 02/02/2023). One complaint was substantiated. One complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 20	{N 000}		
{N 239}	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any	{N 239}		

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

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{N 239}	Continued From page 1 employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 3 employees reviewed had documented completed training in required courses. Caregiver M did not have documentation of completing all required CBRF training courses. This is a repeat violation. See statement of deficiency (SOD) #6XI914, dated 02/08/2024. Findings include: On 06/20/2024 at approximately 10:00 AM, Surveyor requested employee records from Administrator N for Caregiver M to verify compliance with Department Approved Training Courses. First Aid and Choking The record for Caregiver M, hired 09/04/2023 did not contain evidence of training in First Aid and Choking or evidence of meeting an exemption for first aid and choking. Surveyor checked the Wisconsin Community-Based Care and Treatment Registry and Caregiver M was not listed having completed this training. Caregiver M is not a Certified Nursing Assistant (CNA).	{N 239}		

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{N 239}	Continued From page 2 On 06/20/2024 at 11:00 AM, Surveyor interviewed Administrator N, Administrator N confirmed that Caregiver M assists residents with care and would have to administer first aid if necessary. On 06/20/2024 at 11:30 AM, Surveyor asked Administrator N if there was any other documentation that indicated Caregiver M had completed First Aid and Choking training. Administrator N stated, "I gave you all I have, there isn't anything else to find." Surveyor gave Administrator N until 06/21/2024 at noon to provide further documentation. As of 06/21/2024 at noon, no further documentation was provided.	{N 239}		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the	N 389		

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N 389	Continued From page 3 individual service plan (ISP) was not updated for 2 of 2 resident records reviewed when there was a change in resident needs and abilities. Resident 11's ISP was not updated to include interventions for refusing medications. Resident 12's ISP was not updated to include interventions for his/her alcohol use. This is a repeat violation. See statement of deficiency (SOD) #6XI912, dated 02/02/2023. Findings include: Example 1: Resident 11 Resident 11 was admitted to the facility on 02/02/2024 with diagnoses of bipolar affective disorder and Parkinson's. Resident 11's ISP dated 03/15/2024 documented: "Medications administered by staff. 24-Hour supervision. Must supervise and monitor at all times to prevent and stop self abusive behavior. Must be supervised to help prevent and alleviating any destructive behaviors or incidents. Constantly supervise and assist resident in redirecting aggressive/combative behaviors. Communicated needs, ideas independently." Resident 11's progress notes documented: "05/23/2024: [Resident 11] was up all night talking to [him/her] self and looking out the window and many residents are complaining that [s/he talks a lot and doesn't let them sleep. 05/26/24: [Resident 11] didn't want to wake up to take [his/her] medicine or have breakfast, [s/he] said to let [him/her] sleep that we shouldn't bother [him/her].	N 389		

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N 389	Continued From page 4 05/27/24: [Resident 11] didn't want to take [his/her] medication [s/he] started screaming that [s/he] didn't want to ....Gets very irritated when asking [him/her] if [s/he's] ready to take [his/her] meds then starts talking and yelling. 06/02/2024: [Resident 11] refused to get up this morning for breakfast and to take [his/her] medications. [S/he] don't want to get disturbed .... [Resident 11] refused to get up and take [his/her] medications and eat. 06/05/2024: [Resident 11] refused to get up to eat or take the medications because [s/he] is very tired. 8 am. [Resident 11] came PM to take [his/her] medications and eat. Refused the med. 06/06/2024: [Resident 11] refused to get up and take the medications ....Ask [him/her] 7 am, 7:45, 8:15 am ....[Resident 11] refused to get up and take the medication. 06/07/2024: [Resident 11] refused to get up or eat and medications. We ask [him/her] 7:15 am, 7:45 am, 8:15 am, and 8:40 am. 06/09/2024: [Resident 11] got up to have b-fast until 9:15 am ...[S/he] refused take the med. 06/10/2024: [Resident 11] didn't even come to take [his/her] medicine. 06/14/2024: [Resident 11] refused to get up this morning. We wake [him/her] up 3 times. [Resident 11] always comes for lunch late and [s/he] ask for the food quickly and [s/he] start getting angry and yelling at us if we don't give [him/her] food quickly then goes and doesn't eat anything and doesn't want to take [his/her] medications. 06/18/2024: [Resident 11] refused to take [his/her] meds this morning and refused to eat lunch and take [his/her] afternoon med. 06/18/2024: [Resident 11] did not sleep all night. [S/he] was asking for water and milk to take to [his/her] room. [S/he] took it and kept shouting to give it to [him/her] quickly or otherwise [s/he]	N 389		

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N 389	Continued From page 5	N 389		

would call the police because we don't give him food and the food we give to [him/her] is very disgusting and that we are useless people who don't know how to do anything. [S/he] shout and slam the door in my face. This happened at 5 am. 06/19/2024: [Resident 11] refused to take [his/her[morning meds. 3 times tried."

On 06/20/2024 at 9:45 AM, Surveyor interviewed Caregiver L regarding Resident 11 refusing behaviors. Caregiver L stated Resident 11 will refuse medications and meals. Caregiver L stated snacks are always available for residents to take but Resident 11 accuses us of not feeding him/her. Caregiver L stated s/he will reattempt many times to try to get Resident 11 to take his/her medications, but s/he gets irritated and staff get yelled at. Caregiver L stated Resident 11 will tell his/her mom/dad we do not feed him/her but we continue to document all refusals since they occur so frequently. Surveyor asked Caregiver L if the provider put any strategies into place to mitigate Resident 11 refusing. Caregiver L stated no strategies or interventions existed, staff have to come up with their own.

The ISP did not identify updated interventions or approaches for staff to utilize in managing Resident 11 refusing medications.

Example 2: Resident 12

On 06/20/2024, Surveyors reviewed resident records and identified the following:

Resident 12 was admitted to the facility on 11/28/2023 with diagnoses including diabetes and anxiety. Resident 12 is their own legal decision maker. Resident 12's ISP dated 03/04/2024 did not document any interventions for staff to

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N 389	Continued From page 6 mitigate Resident 12's alcohol use. Surveyor reviewed a fax cover sheet dated 06/06/2024 sent to Resident 12's physician documented: " ... [Resident 12] has been getting drunk quite often past couple of weeks, they cannot be getting drunk on property or coming home drunk." Resident 12's progress notes documented: 04/24/2024: " ... [Resident 12] was mad because don't give [her/his] pills [s/he] said [s/he] is going to call the state the med pass doing drugs and also the med pass doesn't give [his/her] med because the resident was drank [sic]. Resident said [s/he] is go to send [Caregiver P], [Caregiver G], [Caregiver O] to jail. 04/24/2024: ... [s/he] said "I want to talk to [him/her]" that last night [his/her] meds wasn't given. That [s/he] needed an ambulance [Caregiver P] didn't believe [him/her] that [Caregiver P] kept telling [him/her] that [s/he] was drunk. 05/24/2024: ...started drinkin [sic] beer very early 9:30p. They were outside smoking and drinking until they opened the door and a mouse got in. They started to catch it in the living room. ... [Resident 12] was going to hit [him/her]. The [Resident 12] went into the room to bother [him/her], came with me very sad and asking me to tell [him/her] to put the music down because the resident need to sleep." On 06/20/2024 at 10:30 AM, Surveyors interviewed Administrator N. S/he shared Resident 12 had been drinking more often and that s/he talked with her/him about not drinking. Administrator N stated that if Resident 12 was going to drink, s/he needed to confine that to her/his personal room, and not to be disruptive to	N 389		

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N 389	Continued From page 7 others. On 06/20/2024 at 11:40 AM, Surveyors conducted an exit interview with Administrator N. Administrator N acknowledged the requirement to have resident ISPs up to date and that Resident 11's and Resident 12's ISPs should have reflected the above needs. Administrator N shared s/he was new to the building and was trying to update all ISPs to be in compliance.	N 389		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that food was stored in a safe, sanitary manner.	N 452		

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N 452	Continued From page 8 Findings include: On 06/20/2024 at 8:30 AM, Surveyor observed a bag of frozen pork chops in the sink located in the kitchen area. On 06/20/2024 at 8:40 AM, Surveyor asked Caregiver I if the pork chops in the sink were going to be served. Caregiver I stated, "I think so, but I am not cooking today, you will have to ask Caregiver L." On 06/20/2024 at 9:00 AM, Surveyor observed that the bag of pork chops were still in the sink. On 06/20/2024 at 9:15 AM, Surveyor asked Caregiver L if the pork chops were going to be served. Caregiver L stated, "Yes, they are for lunch, I am just thawing them out." On 06/20/2024 at 10:00 AM, Surveyor observed the that the bag of pork chops were still in the sink. On 06/20/2024 at 12:00 PM, Surveyor discussed the above concern with Administrator N. Administrator N acknowledged that food should not be in the sink to thaw. Administrator N acknowledged that frozen food should be thawed overnight in the refrigerator.	N 452		