STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017749	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SV SOUTH BELOIT TERRACE	2771 IVA COURT BELOIT, WI 53511

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{N 000}	Initial Comments On 07/19/2023, with information gathered through 08/03/2023, the Bureau of Assisted Living, Southern Regional Office conducted four complaint investigations and a verification visit of Statement of Deficiency [SOD] #705414 at SV South Beloit Terrace (CBRF), located at 2771 Iva Court in Beloit, WI. Eleven citations of noncompliance were issued. Eight (8) of 11 citations were repeat violation issued with SOD 705414, issued 04/14/2023. Four (4) of 11 citations were repeat violations issued with SOD 705413, issued 12/01/2022. One (1) of 11 citations were repeat violations issued with SOD 705411, issued 01/13/2022. One (1) of 11 citations was a repeat violation issued with SOD 9ZA311, issued 11/15/2021. Three (3) of 11 citations were repeat violations issued with SOD JFZC13, issued 02/17/2021. One (1) of 11 citatoins were repeat violations issued with SOD JFZC12, issued 09/29/2020. Two (2) of 11 citations were repeat violations issued with SOD JFZC11, issued 07/21/2020. Four (4) of 11 citations were repeat violations issued with SOD RL8X11, issued 06/08/2020. Three of four complaints were substantiated. Census: 16 Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed.	{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.	{N 196}		

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

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{N 196}	Continued From page 1	{N 196}		

This Rule is not met as evidenced by:
Based on interview and record review, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF.

This requirement is being cited for the fifth time. See SOD 705414, issued on 04/14/2023, SOD 9ZA311, issued on 11/15/2021, SOD JFZC11, issued 07/21/2020, and SOD RL8X11, issued 06/08/2020.

Since a change of ownership desk review was conducted on 10/01/2021, the department has conducted 15 regulatory visits, including desk reviews, complaint investigations, licensing surveys, and verification visits. Out the 15 regulatory visits conducted, 11 of those visits resulted in citations and/or enforcement action.

The findings include:

On 07/19/2023, with information gathered through 08/03/2023, two Surveyors conducted four complaint investigations and a verification visit of Statement of Deficiency [SOD] 705414 issued on 04/14/2023.

Eleven citations of noncompliance were identified. Three of four complaints were substantiated.

N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws
This requirement is being cited for the fourth time. See SOD 705414, issued on 04/14/2023, SOD 9ZA311, issued on 11/15/2021, SOD JFZC11, issued 07/21/2020, and SOD RL8X11, issued

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{N 196}	Continued From page 2 06/08/2020. N0205 DHS 83.14(2)(i) Not Permit A Condition Of Substantial Risk N220 DHS 83.17(2)(a) Employees Screened For Communicable Disease This requirement is being cited for a second time. See Statement of Deficiency (SOD) 705413, issued 12/01/2022. N0352 DHS 83.32(3)(h) Resident Of Residents: Receive Medications This requirement is being cited for the fourth time. See SOD 705414, issued on 04/14/2023, SOD 705413, issued 12/01/2022, SOD JFZC13, issued 02/17/2021, and SOD RL8X11, issued 06/08/2020. N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan This requirement is being cited for the fifth time. See Statement of Deficiency (SOD) 705414, issued 04/14/2023, SOD 705411, issued 01/13/2022, SOD JFZC13, issued 02/17/2021, and SOD RL8X11, issued 06/08/2020. N0415 DHS 83.37(2)(d) Documentation of Medication Administration This requirement is being cited for the fifth time. See Statement of Deficiency (SOD) SOD JFZC13, issued 02/17/2021, SOD JFZC12, issued 09/29/2020, SOD JFZC11, issued 07/21/2020, and SOD RL8X11, issued 06/08/2020. N0425 DHS 83.38(1)(a) Personal Care This requirement is being cited for the second time. See SOD 705414, issued on 04/14/2023.	{N 196}		

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{N 196}	Continued From page 3 N0431 DHS 83.38(1)(g) Health Monitoring This requirement is being cited for the second time. See SOD 705414, issued on 04/14/2023. N0441 DHS 83.39(3) Hand Washing This requirement is being cited for the second time. See SOD 705414, issued on 04/14/2023. N0447 DHS 83.41(1)(c) Dishwashing This requirement is being cited for the third time. See SOD 705414, issued on 04/14/2023, and SOD 705413, issued 12/01/2022. N0481 DHS 83.43(1) Environment Safe, Clean, and Comfortable This requirement is being cited for the third time. See SOD 705414, issued on 04/14/2023, and SOD 705413, issued 12/01/2022. On 04/14/2023, the Department issued special orders to the licensee including the following: "Based on the results of the Department ' s investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that SV South Beloit Terrace: 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 all resident care and treatment related violations identified in Statement of Deficiency (SOD) 705414, the licensee shall develop and implement corrective measures in consultation with a registered nurse (RN) not currently affiliated with the licensee, at the licensee ' s expense. The RN will have knowledge of assisted living regulations (e.g., Wis. Admin. Code ch. 83,	{N 196}		

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{N 196}	Continued From page 4 Wis. Stat. ch. 50) and knowledge of the client groups served by SV South Beloit Terrace. The licensee will provide the RN with a copy of the SOD 705414 along with this Notice and Order letter prior to providing consultation services. Consultation will include the development (or revision) of a written procedure and staff training (as appropriate) to address: A. Medication management and administration, including how the facility will: (a) document medication orders, medication administration, medication errors, and missed/refused doses; (b) ensure residents receive medications at the intervals and dosages prescribed; (c) prevent medication errors; (d) respond to medication errors if they occur; and (e) monitor for adverse side effects. Resources are available at: https://www.dhs.wisconsin.gov/regulations/assisted-living/mmi.htm ADDITIONALLY: - All managers and resident care staff (as appropriate) will receive in-service training regarding the licensee ' s corrective measures to resolve each deficiency identified in SOD 705414. - Training will be documented in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. - Consultation activities, including dates of consultation, will be documented, signed and dated by the consultant. - A copy of the written procedure and all documentation as evidence of meeting the requirements in Order #1 will be made available to department representatives upon request." On 07/19/2023, at approximately 9:00 a.m., Surveyor requested from House Manager EE all evidence of the provider's compliance with Order #1. House Manager EE provided Surveyor with 2	{N 196}		

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{N 196}	Continued From page 5	{N 196}		

forms showing several staffs' signatures with an annotation above the signatures indicating that staff have "read and reviewed all of the policies and procedures in this manual." Surveyor then requested from House Manager EE the manual referenced on the forms. In reviewing the manual, Surveyor observed a care staff job description handout, a resident rights handout, a conduct policy, a "Resident Care and Services Policy and Procedure," which included information in assessments and fall management, a staff on-call policy, a staff call-in policy, a dish washing procedure document, and a food safety handout. In reviewing the manual, Surveyor did not observe any evidence of medication management and administration procedures or training in those procedures as ordered in Order#1.

On 07/19/2023 at 11:11 A.M., House Manager EE told Surveyor the facility had experienced a significant turn over in caregivers within recent months and caregivers were regularly being pulled from other facilities licensed by the licensee to fill open shifts at this facility when scheduled caregivers either take off work by calling-in or not showing up for work without notice. House Manager EE said the facility had also utilized agency staff in recent months. House Manager EE said Former House Manager NN was hired after Former House Manager M left employment in May 2023, but terminated employment after a few weeks. House Manager EE said Former House Manager OO was hired, but left employment after a few weeks at the end of June or early July 2023. House Manager EE told Surveyor s/he had been asked to fill in as the interim house manager for this facility when Former House Manager OO terminated employment in addition to being the house manager at 2 different facilities licensed by the

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{N 196}	Continued From page 6 licensee. On 07/19/2023 at 5:50 P.M., House Manager EE and Surveyor reviewed Order #1, as issued to the licensee on 04/14/2023. House Manager EE told Surveyor the requirements issued to the facility within Order #1 on 04/14/2023 were not completed. On 07/19/2023 at approximately 6:09 P.M., Surveyors conducted an interview with Administrator DD, House Manager EE, and Administrative Assistant HH regarding current issues with noncompliance, including ongoing past noncompliance and the special order issued to the licensee on 04/14/2023. Administrator DD told Surveyors s/he was aware the facility was "not quite there, yet" and "there was more work to be done" to correct the issues with noncompliance. Administrator DD said the facility had struggled with a significant turn over in management including 2 different facility administrators, 2 different facility nurses, and 3 different house managers within recent months. Administrator DD s/he was unable to make completing the requirements issued within Order #1 on 04/14/2023 a priority because s/he was recently unable to be onsite at this facility for approximately 6 weeks related to personal reasons until last week and Former House Manager OO recently terminated employment without notice. On 08/03/2023 at 2:12 P.M., Surveyor conducted an interview with Administrator DD. Administrator DD told Surveyor s/he was not aware of SOD 705414 and did not begin consultation work on correction procedures related to SOD 705414 until after s/he became administrator at this facility on 06/01/2023.	{N 196}		

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{N 196}	Continued From page 7 Compliance History Based on a review of the facilities compliance history since a change of ownership desk review was conducted on 10/01/2021, the department has conducted 15 regulatory visits, including desk reviews, complaint investigations, licensing surveys, and verification visits. Out the 15 regulatory visits conducted, 11 of those visits resulted in citations and/or enforcement action. From 01/26/2023 through 02/16/2023, the department conducted a verification visit of SOD 705413, issued on 12/01/2022, and three complaint investigations. All three complaints were substantiated and 15 violations of noncompliance, including 9 repeat violations of noncompliance, were issued with SOD 705414 on 04/14/2023. On 04/14/2023, the department issued an order to comply with requirements, an order not to admit new or additional residents, an order of imposed forfeiture, and a notice of special orders. The 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 resident's physical and mental health needs. For all resident care and treatment related violations identified in Statement of Deficiency (SOD) 705414, the licensee shall develop and implement corrective measures in consultation with a registered nurse (RN) not currently affiliated with the licensee, at the licensee ' s expense. 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 by SV South Beloit Terrace. The licensee will provide the	{N 196}		

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{N 196}	Continued From page 8 RN with a copy of the SOD 705414 along with this Notice and Order letter prior to providing consultation services. Consultation will include the development (or revision) of a written procedure and staff training (as appropriate) to address: A. Medication management and administration, including how the facility will: (a) document medication orders, medication administration, medication errors, and missed/refused doses; (b) ensure residents receive medications at the intervals and dosages prescribed; (c) prevent medication errors; (d) respond to medication errors if they occur; and (e) monitor for adverse side effects. Resources are available at: https://www.dhs.wisconsin.gov/regulations/assisted-living/mmi.htm ADDITIONALLY: - All managers and resident care staff (as appropriate) will receive in-service training regarding the licensee ' s corrective measures to resolve each deficiency identified in SOD 705414. - Training will be documented in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. - Consultation activities, including dates of consultation, will be documented, signed and dated by the consultant. - A copy of the written procedure and all documentation as evidence of meeting the requirements in Order #1 will be made available to department representatives upon request. 2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., the licensee shall develop and implement corrective measures to achieve compliance with requirements specified by Wis. Admin. Code § DHS 83.48(1)(a) and ensure an integrated smoke detector is installed in all required locations. The licensee will obtain the installation of any needed	{N 196}		

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{N 196}	Continued From page 9 upgrades to the integrated smoke and heat detection system in order to meet the requirements specified by Wis. Admin. Code ch. DHS 83. Department approval is required before installing a smoke and heat detection system. WITHIN 45 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). The licensee will retain documentation to evidence OPRI completed the plan review and approved of the proposed changes to the existing smoke and heat detection system. Additionally, the licensee will obtain documentation from the service contractor to verify effective operation of the system after completion of the approved scope of work. This documentation will be maintained at the facility and made available to department representatives upon request." On 02/23/2023, the department issued the licensee a warning of systemic noncompliance related to findings at the providers five (5) facilities, and that "Failure to take immediate steps to achieve consistent and substantial compliance with respective regulatory codes or statutes will result in one or more revocations of licensure." From 07/27/2022 through 08/26/2022, the department conducted a standard licensing survey, a verification visit of SOD 705412, issued 06/02/2022, and a complaint investigation. The complaint was substantiated and 8 citations were issued with SOD 705413 on 12/01/2022 including: N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect N0220 DHS 83.17(2)(a) Employees Screened	{N 196}		

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{N 196}	Continued From page 10 For Communicable Disease N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medications N0447 DHS 83.41(1)(c) Dishwashing N0454 DHS 83.42(1) Resident Records Maintained N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable N0534 DHS 83.48(1)(a) Smoke Detection System N0535 DHS 83.48(1)(b) Smoke And Heat Detectors Per Nfpa 72 On 12/01/2022, the department issued an order to comply with requirements and an order of imposed forfeiture. On 03/01/2022, the department conducted a verification visit of SOD 705411, issued on 01/13/2022, and a complaint investigation. The complaint was unsubstantiated and 2 citations were issued with SOD 705412 on 06/02/2022 including: N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet N0507 DHS 83.46(1)(f) Combustibles On 06/02/2022, the department issued an order to comply with requirements and an order of imposed forfeiture. On 12/08/2021, the department conducted a complaint investigation. The complaint was substantiated and 7 violations of noncompliance were issued with SOD 705411 on 01/13/2022 including: N0383 DHS 83.35(1)(c) Listed Areas For Assessments N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet	{N 196}		

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{N 196}	Continued From page 11 N0439 DHS 83.39(1) Infection Control Program N0452 DHS 83.41(3)(b) Food Safety N0499 DHS 83.45(3) Toxic Substances N0507 DHS 83.46(1)(f) Combustibles On 01/13/2023, the department issued an order to comply with requirements. On 11/21/2021, the department conducted a desk review verification visit of SOD 9ZA311, issued on 11/15/2021. The violation issued with SOD 9ZA311 was corrected and no violations of noncompliance were issued. On 10/07/2021, the department conducted a desk review and issued one violation of noncompliance with SOD 9ZA311 on 11/15/2021 including: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws On 1/15/2021, the department issued an order to comply with requirements, a notice of imposed forfeiture, a notice of accruing forfeiture, and a notice of special orders. The special orders included: "1. Pursuant to Wis. Stat. § 50.03(5g)(b)3., effective immediately, the licensee shall comply with the requirements specified by Wis. Stat. ch. 50 and Wis. Admin. Code ch. DHS 83 that establish the standards for the operation of the Community Based Residential Facility in order to protect and promote the health, safety and welfare of the residents. AS SOON AS PRACTIABLE AND WITHOUT DELAY, within 10 days of receipt of this notice, the licensee shall achieve and maintain substantial compliance with all requirements. All operational and resident records required as evidence of compliance with applicable rules will be available to department representatives upon request. The Department may, without notice, conduct an inspections to verify the licensee's corrective action at any time	{N 196}		

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after the date of compliance. Pursuant to Wis. Stat. § 50.03(5g)(cm), the department may impose a $200 inspection fee for an on-site inspection to review compliance of violations resulting in enforcement action. ADDITIONALLY: WITHIN 10 DAYS of receipt of this notice, the licensee may request an extension for the date of compliance. The request for an extension must be submitted to the Assisted Living Regional Director, Southern Regional Office, at DHSDQABALSRO@dhs.wisconsin.gov. The Regional Director will commmunicate to the licensee a decision on the date of compliance extension."

On 09/14/2021, the department conducted a verification visit of SOD JFZC15, issued on 09/07/2021, and a complaint investigation. The complaint was unsubstantiated and no violations of noncompliance were issued.

On 06/16/2021, the department conducted a verification visit of SOD JFZC14, issued on 06/16/2021, and a complaint investigation. As a result, 2 violations of noncompliance were issued with SOD JFZC15 on 09/07/2021 and the complaint was substantiated. The 2 violations of noncompliance included:
N0163 DHS 83.12(4)(a) Reporting When Resident's Whereabouts Unknown
N0426 DHS 83.38(1)(b) Supervision
On 09/07/2021, the facility was issued an order to comply with requirements and a notice of imposed forfeiture.

From 04/14/2021 through 04/27/2021, the department conducted a verification visit of SOD JFZC13, issued on 02/17/2021, and a complaint investigation. As a result, 2 violations of noncompliance were issued with SOD JFZC14 on

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SV SOUTH BELOIT TERRACE	2771 IVA COURT BELOIT, WI 53511

(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 196}	Continued From page 13 06/16/2021 and the complaints was substantiated. The 2 violations of noncompliance included: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation N0348 DHS 83.32(3)(d) Rights Of Residents: Free From Mistreatment On 06/16/2021, the facility was issued an order to comply with requirements, a notice of imposed forfeiture, and a notice of special orders. The special orders included: "1. Pursuant to Wis. Stat. § 50.03(5g)(b)6., EFFECTIVE IMMEDIATELY, the licensee shall develop and implement corrective measures to ensure the administrator supervises the daily operation and designates a qualified resident care staff as in charge whenever the administrator is absent from the CBRF. The corrective measures shall ensure all employees protect and promote the right of each resident to be free from mistreatment. The licensee will provide in-service training to all managers and resident care staff on the corrective actions taken to resolve each deficiency identified in SOD JFZC14. Training will documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and evidence of successful completion of the training." From 01/21/2021 through 01/27/2021, the department conducted a verification visit of SOD JFZC12, issued on 09/29/2020, and a complaint investigation. As a result, 5 violations of noncompliance were issued with SOD JFZC13 on 02/17/2021 and the complaints was substantiated. The 5 violations of noncompliance included: N0352 DHS 83.32(3)(h) Rights Of Residents:	{N 196}		

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{N 196}	Continued From page 14 Receive Medicaitons N0383 DHS 83.35(1)(c) Listed Areas For Assessments N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0415 DHS 83.37(2)(d) Documentation Of Medication Administration N0613 DHS 83.55(4)(a) Bath And Toilet Areas: Privacy On 02/17/2021, the facility was issued an order to comply with requirements, a notice of imposed forfeiture, and a notice of special orders. The special orders included: "1. Pursuant to Wis. Stat. §§ 50.03(5g)(b)3. and (b)6., EFFECTIVE IMMEDIATELY, the licensee shall comply with the requirements specified by Wis. Admin. Code § DHS 83.32(3)(h). That is, the licensee will protect and promote each resident's right to receive all prescribed medications in the dosage and at intervals prescribed by the resident's physician. In consultation with a Registered Nurse (RN), the licensee will develop (or review/revise) procedures to address: - Diabetes Management to include standards of practice for the assessment, care planning, and provision of services for residents with diabetes. Additional information and resources addressing diabetes can be located on the department website: https://www.dhs.wisconsin.gov/diabetes/index.htm - Medication management and administration, including how the facility will: (a) document medication orders, medication administration, medication errors, and missed/refused doses; (b) ensure residents receive medications at the intervals and dosages prescribed; (c) prevent medication errors; (d) respond to medication errors if they occur; and (e) implement standards of practice for insulin management. Resources	{N 196}		

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{N 196}	Continued From page 15 are available at: https://www.dhs.wisconsin.gov/regulations/assisted-living/mmi.htm. The licensee will provide the RN with a copy of the Statement of Deficiency (SOD) #JFZC13, along with this Notice and Order letter prior to providing consultation services. The licensee shall obtain a signed and dated statement from the RN to verify participation in the development (or review) of the facility's written procedures required by Order #1. Additionally: - All managers and service providers (as appropriate) will receive in-service training regarding the facility's written procedures required by Order #1. - Training will be documented in employee files and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content. - A copy of the written procedures and all documentation as evidence of meeting the requirements in Order #1 will be made available to department representatives upon request." On 09/18/2020, the department conducted a verification visit of SOD JFZC11, issued on 07/21/2020, and a verification visit of SOD RL8X11, issued on 06/08/2020. As a result, 1 repeat violation was issued with JFZC12 on 09/29/2020 with a conditional license being granted as of 09/30/2020. The 1 repeat violation included: N0415 DHS 83.37(2)(d) Documentation of Medication Administration On 09/29/2020, the facility was issued an order to submit a plan of correction and a notice of special orders. The special orders included: "1. Based on the results of the Department's investigation, and pursuant to Wis. Stat. §§ 50.03(5g)(b)3. and (b)6., the licensee will correct	{N 196}		

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{N 196}	Continued From page 16 all violations identified in SOD # JFZC12 and will achieve substantial compliance with all laws and administrative rules governing the facility and its operation prior to expiration of the facility's Probationary License. IF the licensee has not achieved substantial compliance with all laws and administrative rules governing the facility and its operation AND IF the violations identified in SOD # JFZC12 remain substantially uncorrected, the PROBATIONARY LICENSE for SV South Beloit Terrace may be INVALID and the Department may NOT ISSUE A REGULAR LICENSE for SV South Beloit Terrace, 2771 Iva Court, Beloit, WI 53511. This NOTICE is provided in accordance with Wis. Stat. § 50.03(4m)(b), whereby, if the applicant for licensure as a community-based residential facility has not been previously licensed under this subchapter or if the community-based residential facility is not in operation at the time application is made, the department shall issue a probationary license. Prior to the expiration of a probationary license, the department shall evaluate the community-based residential facility. In evaluating the community-based residential facility, the department may conduct an inspection of the community-based residential facility. If, after the department evaluates the community-based residential facility, the department finds that the community-based residential facility meets the applicable requirements for licensure, the department shall issue a regular license under sub. (4)(a)1.b. If the department finds that the community-based residential facility does not meet the requirements for licensure, the department may not issue a regular license under sub. (4)(a)1.b. Wis. Admin. Code § DHS 83.08(2), whereby the Department shall deny a probationary license or regular license to any applicant who does not	{N 196}		

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{N 196}	Continued From page 17 substantially comply with any provision of Wis. Admin. Code ch. DHS 83 or Wis. Stat. ch. 50." On 07/21/2020, the department conducted a complaint investigation. The complaint was unsubstantiated and no violations of noncompliance were issued. From 05/27/2020 through 06/16/2020, the department conducted a standard licensing survey and 2 complaint investigations. As a result, 7 violations of noncompliance were issued with SOD JFZC11 on 07/21/2020 and both complaints were substantiated. The 7 violations of noncompliance included: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0386 DHS 83.35(3)(a) Comprehensive Individual Service Plan N0407 DHS 83.37(1)(h) Scheduled Psychotropic Medications N0408 DHS 83.37(1)(i) PRN Psychotropic Medication N0410 DHS 83.37(1)(k) Medication Error Or Adverse Reaction N0415 DHS 83.37(2)(d) Documentation Of Medication Administration N0416 DHS 83.37(2)(e) Other Administration Given Or Delegated By RN On 07/21/2020, the facility was issued an order to submit a plan of correction, a notice of imposed forfeiture, and a notice of special orders. The special orders included: "1. Based on the results of the Department's investigation, and pursuant to Wis. Stat. §§ 50.03(5g)(b)3. and (b)6., the licensee will correct all violations identified in SOD # JFZC11 and will achieve substantial compliance with all laws and administrative rules governing the facility and its operation prior to expiration of the facility's	{N 196}		

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{N 196}	Continued From page 18 Probationary License. IF the licensee has not achieved substantial compliance with all laws and administrative rules governing the facility and its operation AND IF the violations identified in SOD # JFZC11 remain substantially uncorrected, the PROBATIONARY LICENSE for SV South Beloit Terrace may be INVALID and the Department may NOT ISSUE A REGULAR LICENSE for SV South Beloit Terrace, 2771 Iva Court, Beloit, WI 53511. This NOTICE is provided in accordance with Wis. Stat. § 50.03(4m)(b), whereby, if the applicant for licensure as a community-based residential facility has not been previously licensed under this subchapter or if the community-based residential facility is not in operation at the time application is made, the department shall issue a probationary license. Prior to the expiration of a probationary license, the department shall evaluate the community-based residential facility. In evaluating the community-based residential facility, the department may conduct an inspection of the community-based residential facility. If, after the department evaluates the community-based residential facility, the department finds that the community-based residential facility meets the applicable requirements for licensure, the department shall issue a regular license under sub. (4)(a)1.b. If the department finds that the community-based residential facility does not meet the requirements for licensure, the department may not issue a regular license under sub. (4)(a)1.b. Wis. Admin. Code § DHS 83.08(2), whereby the Department shall deny a probationary license or regular license to any applicant who does not substantially comply with any provision of Wis. Admin. Code ch. DHS 83 or Wis. Stat. ch. 50. 2. Pursuant to Wis. Stat. §§ 50.03(5g)(b)3., and (b)6., effective immediately, the facility will comply	{N 196}		

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{N 196}	Continued From page 19 with requirements specified by Wis. Admin. Code § DHS 83.37(2)(e). That is, injectable, 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. Non-licensed employees may only administer injectable, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally as delegated nursing acts, pursuant to s. N 6.03(3). When assigned, delegated nursing tasks will be addressed in the CBRF employee's job description and personnel file. The employee's file will include a written plan for RN supervision and direction of delegated nursing acts. In the supervision and direction of delegated nursing acts an RN shall: a) delegate tasks commensurate with education, preparation, and demonstrated abilities of the person supervised, b) provide direction and assistance to those supervised, c) observe and monitor the activities of those supervised, and d) evaluate the effectiveness of acts performed under supervision. When submitting the facility's written plan of correction, the licensee will include under separate cover, the name, address, telephone number, and license number for the Registered Nurse (RN) employed by or under contract with the facility to supervise and direct delegated nursing acts." On 01/07/2020, the department conducted a verification visit of SOD 7EHH11, dated 08/15/2019, and conducted 2 complaint investigations. As a result, 11 citations of noncompliance were issued with RL8X11 on 06/08/2020 and both complaints were substantiated. The 11 citations of noncompliance included:	{N 196}		

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{N 196}	Continued From page 20 N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0249 DHS 83.22(3) Training In Daily Living Activities Required N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medications N0387 DHS 83.35(3)(b) Service Plan Development Parties Involved N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0410 DHS 83.37(1)(k) Medication Error Or Adverse Reaction N0415 DHS 83.37(2)(d) Documentation Of Medication Administration N0427 DHS 83.38(1)(c) Leisure Time Activities N0454 DHS 83.42(1) Resident Records Maintained Y3234 DHS 50.09(1)(e) Treatment On 06/08/2020, the facility was issued an order to submit a plan of correction and a notice of imposed forfeiture. On 10/01/2021, the department conducted a change of ownership desk review and issued this facility a probationary license. A conditional license was issued to include Licensee TT would assume responsibility for SOD 7EHH11 (dated 08/15/2019 and issued prior to the change of ownership review) to develop a plan of correction in each SOD, pay any outstanding verification visit, and correct violations. Summary: The licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF.	{N 196}		

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N 205	Continued From page 21	N 205		
N 205	83.14(2)(j) Not permit a condition of substantial risk. The licensee may not permit the existence or continuation of any condition which is or may create a substantial risk to the health, safety or welfare of any resident. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure the existence of any condition which may create a substantial risk to health, safety, or welfare of any resident was not permitted. On 07/19/2023, Caregiver II was observed to take over 3.5 hours to administer morning medications to residents. During this observation, an odor indicative of marijuana was observed on the medication cart and Caregiver II struggled to appropriately and timely administer resident medications. Caregiver II did not appropriately monitor resident health prior to administration of certain medications, such as monitoring blood glucose readings prior to insulin administration. Several resident medications were administered late, including insulin, some medications were not administered, and Caregiver II did not always document the administration or lack of administration appropriately in the resident MARs. Caregiver II exhibited difficulty reading and understanding the electronic medication record (MAR) and medication packaging. Caregiver II was observed to have difficulty finding medications and supplies within the medication cart and did not appropriately respond to questions from residents and from the surveyor.	N 205		

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N 205	Continued From page 22 The findings include: This CBRF is licensed as a Class CNA (non-ambulatory) facility serving up to 20 residents of advanced age, with irreversible dementia, physical disabilities, and/or terminally illness. The facility's current census was 16 residents. On 07/19/2023, Surveyors conducted a complaint investigation and verification visit regarding concerns with medication administration. On 07/19/2023 at 7:30 A.M., Surveyor entered the facility and observed two caregivers on duty. Surveyor observed Caregiver II standing at the medication cart located near the fireplace in the dining room area of the facility and Caregiver JJ located in the facility's open concept kitchen. Caregiver II told Surveyor s/he usually worked at another facility licensed by Licensee TT, but was filling an open shift on this morning at this facility. Caregiver II told Surveyor this was his/her second time working as a caregiver administering medications to the residents at this facility. Surveyor asked Caregiver II if a house manager was available at this facility and Caregiver II responded s/he and Caregiver JJ were the only staff currently available at this facility. Caregiver II told Surveyor s/he did not know Caregiver JJ's name and did not know who the current house manager was for this facility. Surveyor observed Caregiver II ask Caregiver JJ to call a house manager to inform them of Surveyor's arrival. On 07/19/2023 between approximately 07:40 A.M. and approximately 11:00 A.M., Surveyor observed as Caregiver II conducted a portion of the morning medication pass for approximately 3.5 hours. Each time Caregiver II and Surveyor	N 205		

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approached the medication cart during this medication pass observation, Surveyor observed a strong odor indicative of marijuana at the medication cart. Surveyor observed two bags located on top of the medication cart, both of which Caregiver II told Surveyor belonged to Caregiver II.
Between approximately 7:40 A.M. and approximately 10:37 A.M., Surveyor observed a cellular phone located on top of the medication cart regularly ringing and/or emitting notification sounds. At approximately 10:37 A.M., Surveyor asked Caregiver II if the phone was a work or facility phone. Caregiver II told Surveyor the phone was not a work or facility phone as Surveyor observed Caregiver II turn off the phone and place in the top drawer of the medication cart.

On 07/19/2023 between 7:40 A.M. until approximately 8:26 A.M., Surveyor observed as Caregiver II conducted morning medication administration related to Resident 3. Surveyor observed Resident 3 seated at table in the dining room. Surveyor observed Caregiver II gather Resident 3's blood glucose monitoring supplies from the medication cart and approach Resident 3. Following Caregiver II's monitoring of Resident 3's blood glucose, Surveyor observed Resident 3 ask Caregiver II for 2 capsules of loperamide [a medication to treat diarrhea], Flexaril [cyclobenzaprine; muscle relaxant medication] for his/her pain, and prednisone [a corticosteroid medication] along with "all of [his/her] other morning medications." Surveyor observed Caregiver II dispense Resident 3's morning medications in tablet/capsule form into a medication cup, including Resident 3's 10 mg (milligram) tablet of prednisone and 10 mg tablet of Flexaril. Surveyor observed Caregiver II did

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not dispense any loperamide, as specifically requested by Resident 3. At 7:56 A.M., Surveyor observed Caregiver II approach Resident 3 with the medications, as dispensed in the cup, and hand the cup to Resident 3. Surveyor observed Resident 3 pour the medications out on the table and tell Caregiver II s/he would not take the medications until all of his/her medications were dispensed. Surveyor observed Resident 3 tell Caregiver II s/he specifically asked for 2 capsules of loperamide and the loperamide capsules were not in the medication cup. Surveyor observed Resident 3 tell Caregiver II the loperamide capsules were small, brown colored capsules and s/he wanted them along with all of his/her morning medications. Surveyor observed Resident 3 become upset, moving all of the medications around on the table with his/her fingers, and loudly tell Caregiver II s/he did not believe his/her Flexaril and prednisone tablets were included in the cup if his/her loperamide was not dispensed. Surveyor observed as Caregiver II picked up all of the medications from the table, returned them to the medication cup, and tell Resident 3 the loperamide was an 'as needed' medication and s/he could not administer 2 loperamide to Resident 3. Surveyor observed Caregiver II return to the medication cart with the medications and review Resident 3's electronic medication administration record (MAR) for several minutes. Included within Resident 3's MAR, Surveyor observed an order for loperamide including, "Take 2 capsules by mouth after first loose stool, then 1 capsule by mouth after each additional loose stool." Surveyor observed Caregiver II dispense 1 capsule of loperamide into the medication cup with the other medications and return to Resident 3. Surveyor observed Caregiver II tell Resident 3, "I [Caregiver II] need to take [Resident 3's]

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temperature before [Caregiver II] can give [Resident 3] the Desitin [a topical barrier cream for skin, of which was not ordered for Resident 3] [Caregiver II] just added to [Resident 3's] pills." Surveyor observed Resident 3 loudly tell Caregiver II, "No, you [Caregiver II] do not. That is not what [Resident 3] asked for, [Resident 3] asked for 2 loperamide. I [Resident 3] know [Resident 3's] medications, [Resident 3] needs them." Surveyor observed Caregiver II respond to Resident 3, "I [Caregiver II] can not give [Resident 3] 2 loperamide." Surveyor observed Resident 3 respond loudly to Caregiver II, "I [Resident 3] know my [Resident 3's] medications, 2 loperamide are ordered." Surveyor observed Caregiver II tell Resident 3 to calm down and that it was Caregiver II's second time "on the med [medication] cart." Surveyor observed Resident 3 did not take any of the medications dispensed to him/her. Surveyor observed Caregiver II take the medications from Resident 3, return to the medication cart, and remove the 1 capsule of loperamide from the medication cup. Surveyor observed as Caregiver II attempted to return the loperamide capsule to slot #20 on Resident 3's loperamide blister pack before dropping the loperamide capsule on the floor of the dining room. Surveyor observed Caregiver II pick up the capsule from the floor and attempt a second time to return the capsule to slot #20 on Resident 3's loperamide bubble pack. Surveyor observed Caregiver II rummaging through the top drawers of the medication cart and on top of the cart stating s/he would normally put this capsule back in to the bubble pack but s/he could not find any tape in/on the medication cart. Caregiver II told Surveyor taping a medication back into a bubble pack was the facility's process when the wrong medication was dispensed, or popped out of the bubble pack and not administered to the resident.

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N 205	Continued From page 26 Surveyor observed Caregiver II place Resident 3's loperamide capsule into a separate medication cup and place it on the top of the medication cart. Surveyor observed Caregiver II move the medication cart to the other side of the dining room fireplace, closer to Resident 3. Surveyor observed Caregiver II ask Resident 3 to repeat the medication names Resident 3 needed. Surveyor observed Resident 3 repeat s/he wanted all of his/her morning medications including 2 capsules of loperamide, Flexaril, and prednisone. Surveyor observed Caregiver II review Resident 3's electronic MAR and tell Resident 3 Tylenol (acetaminophen; pain relieving medication and fever reducer) was ordered "as needed" and Caregiver II could not figure out another pain medication on the list of medications for Resident 3. Surveyor observed Caregiver II remove Resident 3's Flexaril tablet and prednisone tablet from the medication cup while reviewing Resident 3's electronic MAR including pictures of each medication. Caregiver II stated, "Both are here, I [Caregiver II] do not see what medication [Caregiver II] is missing." Surveyor observed Caregiver II put both of medication cups into the top drawer of the cart. At 8:14 A.M., Caregiver II asked House Manager GG, house manager at a different facility licensed by Licensee TT, to come to the medication cart to find Resident 3's prednisone because s/he was unable to find it in Resident 3's 'as needed' medications. Surveyor observed House Manager GG approach the medication cart, review Resident 3's electronic MAR, and tell Caregiver II prednisone, Flexaril, and 2 loperamide capsules were ordered for Resident 3. Surveyor observed Resident 3 loudly state, "I [Resident 3] know. I [Resident 3] am supposed to have [his/her] blood pressure checked, too, before medications, but that has not happened. Surveyor observed	N 205		

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N 205	Continued From page 27 Caregiver II tell Resident 3 s/he already checked Resident 3's blood pressure. Surveyor observed Resident 3 state, "No, you [Caregiver II] did not." Surveyor observed Caregiver II respond, "Oh yeah, I [Caregiver II] checked your blood sugar." Surveyor observed Caregiver II take Resident 3's blood pressure at the dining room table. Surveyor observed Caregiver II return to the medication cart, place the loperamide capsule from the separate medication cup in with the other dispensed medications, and handed the medications to Resident 3. Resident 3 asked Caregiver II if s/he was sure everything ordered for and requested by Resident 3 was in the medication cup. Surveyor observed Resident 3 repeat, "I [Resident 3] want 2 loperamide capsules." Surveyor observed Caregiver II state s/he did not understand Resident 3's medication orders after House Manager GG told Caregiver II to administer Resident 3 a second loperamide capsule to equal 2, as ordered and requested. Surveyor observed Caregiver II dispense and administer a second capsule of loperamide to Resident 3. Surveyor observed Caregiver II return to the medication cart and remove a new, unopened box of Trelegy Ellipta inhaler labeled for Resident 3 from the lower drawer. Surveyor observed Caregiver II open the box and remove another sealed package containing Resident 3's inhaler. Surveyor observed Caregiver II hand the unsealed package to Resident 3. Surveyor observed Resident 3 respond, "I [Resident 3] can not open this." Surveyor observed Caregiver II open the package and hand the inhaler to Resident 3. Surveyor observed Resident 3 administer one inhalation of Trelegy Ellipta inhaler and hand it back to Caregiver II. Surveyor observed Caregiver II return the inhaler to the medication cart and document administration of Resident 3's medications in the electronic MAR.	N 205		

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N 205	Continued From page 28 On 07/19/2023 at 8:27 A.M., Surveyor observed Resident 14 approach the medication cart in his/her wheelchair. Surveyor observed Resident 14 ask Caregiver II if s/he could be administered his/her inhalers. Surveyor observed Resident 14 state, "I [Resident 14] always get both of my [Resident 14's] inhalers in the morning." Caregiver II told Surveyor s/he already administered one of Resident 14's inhalers earlier in morning. Surveyor observed Caregiver II dispense and hand a Symbicort inhaler [inhaled respiratory medication] to Resident 14, and Surveyor observed Resident 14 administer 1 inhalation of Symbicort to self before handing it back to Caregiver II. Surveyor observed Caregiver II did not observe Resident 14's administration of the inhaler, did not cue Resident 14 to take a second inhalation, as prescribed, and did not document administration of this inhaler in Resident 14's electronic MAR. Surveyor asked Caregiver II at what time Resident 14 was to receive administration of Symbicort inhaler. Caregiver II told Surveyor s/he did not look at Resident 14's MAR to review the orders before s/he dispensed the Symbicort inhaler to Resident 14 and stated, "There is just so much coming at me [Caregiver II]." Surveyor observed Resident 14 continue to sit near the medication cart, looking at Caregiver II as Caregiver II looked at Resident 11's electronic MAR. Surveyor observed Resident 14 state, "I [Resident 14] can see this is going to take awhile" as Resident 14 started to wheel his/her chair away from the medication cart. Surveyor observed Caregiver II announce towards Resident 14, "I [Caregiver II] will get to [administer] the rest of your [Resident 14's] medications later." Surveyor reviewed Resident 14's demographic data, practitioner's orders, and July 2023 MAR,	N 205		

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as received by House Manager EE. Resident 14 was admitted to the facility on 01/17/2020 and had diagnoses including chronic obstructive pulmonary disease [COPD]. Resident 14's orders included a prescription for 2 inhalations of Symbicort inhaler twice daily. Resident 14's MAR for 07/19/2023 included Caregiver II's documented administration of Symbicort inhaler to Resident 14 at 11:29 A.M., 2 hours after this medication was administered to Resident 14.

On 07/19/2023 at 8:34 A.M., Surveyor observed as Caregiver II conducted morning medication administration related to Resident 11. Surveyor observed Caregiver II remove Resident 11's medication bubble packs containing famotidine [Pepcid; gastric reflux medication], Tylenol [acetaminophen], and Eliquis [anticoagulant medication] from the medication cart. Surveyor observed Caregiver II dispense 1 half of a tablet of famotidine and two tablets of Tylenol into a medication cup. Surveyor did not observe Caregiver II dispense Eliquis into the medication cup before returning all three bubble packs to the medication cart. Caregiver II told Surveyor s/he was going to administer the medications to Resident 11, as dispensed. Surveyor reviewed the medications within the medication cup with Caregiver II and asked if s/he was sure s/he dispensed all of Resident 11's medications, as scheduled to be administered. Caregiver II said, "I [Caregiver II] thought I [Caregiver II] popped out all of them out [of Resident 11's bubble packs]." Surveyor observed Caregiver II remove the same three bubble packs from the medication cart for a second time. Surveyor observed Caregiver II find a small, white, loose tablet at the bottom of the medication drawer and place it within the medication cup containing other medications dispensed for Resident 11. Surveyor asked

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N 205	Continued From page 30 Caregiver II if s/he was sure that medication was Resident 11's Eliquis. Caregiver II reviewed the medications in the cup and compared them to the pictures included in Resident 11's electronic MAR. Caregiver II told Surveyor s/he realized Resident 11's Eliquis medication was tan/pink in color and was not included in the medications s/he had dispensed. Surveyor observed Caregiver II remove the small, white tablet s/he found at the bottom of the cart and place it in a separate medication cup. Caregiver II gave that separate medication cup to House Manager GG and told him/her s/he found the tablet at the bottom of the cart and it needed to be destroyed. Surveyor observed Caregiver II dispense Resident 11's Eliquis from the bubble pack and add it to the other medications dispensed for Resident 11 before administering the medications to Resident 11. Surveyor reviewed Resident 11's demographic data, practitioner's orders, and July 2023 MAR, as received by House Manager EE. Resident 11 was admitted to the facility on 05/03/2022. Resident 11's practitioner's orders and July 2023 MAR included a prescription for Eliquis 5 mg to be administered by mouth twice daily for deep vein thrombosis and pulmonary embolism, both potentially life threatening diagnoses. On 07/19/2023 at 8:45 A.M., Surveyor observed as Caregiver II conducted morning medication administration related to Resident 19, who is blind in his/her right eye. Surveyor observed Caregiver II dispense several different oral medications into a medication cup for Resident 19. Surveyor observed Caregiver II approach Resident 19 from Resident 19's right side as Resident 19 was seated at a dining room table. Surveyor observed all of the medications from the medication cup spill on to the table as Caregiver II handed the	N 205		

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medications to Resident 19. Resident 6, seated across from Resident 19 at the table, assisted Resident 19 locate two medications caught under Resident 19's left arm that Caregiver II did not notice as s/he picked up the other medications from the table.
Surveyor reviewed Resident 19's demographic data, as received by House Manager EE. Resident 19 was admitted to the facility on 03/05/2020 and had diagnoses including "mental handicap" and being blind in Resident 19's right eye.

On 07/19/2023 from 8:59 A.M. until approximately 9:23 A.M., Surveyor observed as Caregiver II conducted morning medication administration related to Resident 12. Surveyor observed Caregiver II dispense several different oral medications into a medication cup for Resident 12, including metroprolol (blood pressure and heart failure medication) 12.5 mg and dicyclomine (medication used for irritable bowel syndrome) 10 mg. Surveyor observed Caregiver II remove Resident 12's Nyamyc antifungal, topical powder container from the medication cart. At 9:10 A.M., Surveyor observed Caregiver II administer Resident 12's oral medications to Resident 12 seated in a wheelchair located in Resident 12's bedroom. Surveyor observed Caregiver II did not monitor any vital signs for Resident 12 prior to medication administration. Following administration of Resident 12's oral medications, Surveyor observed Caregiver II ask Resident 12 if there was anywhere s/he wanted the Nyamyc antifungal, topical powder to be applied and if Resident 12 itched anywhere. Surveyor observed Resident 12 tell Caregiver II "No." Caregiver II told Surveyor s/he did not know where the Nyamyc powder was to be applied and left Resident 12's room without administration of

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Nyamyc powder, as ordered, and returned to the medication cart. Caregiver II told Surveyor Resident 12 had eaten breakfast at approximately 7:40 A.M. earlier that morning, over an hour before Resident 12 was administered dicyclomine by Caregiver II.
At the medication cart, Surveyor asked House Manager EE about Resident 12's order for Nyamyc powder. House Manager EE told Surveyor Resident 12 had a new, red, raw rash identified to Resident 12's groin area approximately 1 week ago on 07/13/2023. House Manager EE told Caregiver II it was not enough to ask Resident 12 if /she had an itchy area in order to determine application. Surveyor observed House Manager EE tell Caregiver II to apply Resident 12's Nyamyc powder to Resident 12's groin the next time Caregiver II assisted Resident 12 with toileting and document in Resident 12's MAR after administered.
At 9:18 A.M., Surveyor observed Caregiver II return to Resident 12's room with an automatic blood pressure cuff. Surveyor observed Caregiver II apply the blood pressure cuff below (distal to) Resident 12's left elbow. Surveyor observed a diagram including instruction for correct application of the cuff to be placed just above (proximal to) the elbow. Surveyor asked Caregiver II if s/he was sure s/he had properly placed the cuff based on the diagram. Caregiver II told Surveyor s/he placed the cuff below the elbow sometimes and sometimes above it. Caregiver II stated, "I [Caregiver II] don't really pay attention. It has been awhile since someone showed me [Caregiver II] how to take a blood pressure." Surveyor observed Caregiver II continue taking Resident 12's blood pressure and pulse with the cuff located below the elbow until a reading could not be established. Surveyor asked Caregiver II about proper placement of the

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cuff a second time. Surveyor observed Caregiver II place the cuff based on the diagram instructions and Resident 12's blood pressure and pulse were established. At 9:23 A.M., Caregiver II returned to the medication cart and documented Resident 12's pulse and administration of Resident 12's metroprolol, even though Resident 12's metroprolol was administered at 9:10 A.M. prior to Resident 12's pulse being monitored.
Surveyor reviewed Resident 12's demographic data, practitioner's orders, and July 2023 MAR, as received by House Manager EE. Resident 12 was admitted to the facility on 09/16/2013 and had diagnoses including mitral and aortic valve [heart] insufficiency and hypertension. Resident 12's practitioners' orders and July 2023 MAR included a prescription for metroprolol 12.5 mg to be administered for elevated heart rate and "Update MD [medical doctor] if pulse is less than 55, or greater than 120 BPM [beats per minute]." Resident 12's practitioner's orders and July 2023 MAR included a prescription for dicyclomine 10 mg to be administered "...by mouth twice a day before meals for IBS [irritable bowel syndrome]." Resident 12's July 2023 MAR directed administration of dicyclomine related to Resident 12's morning and evening meals. Resident 12's practitioner's order and July 2023 included a prescription for Nyamyc to be applied "..topically to affected area 3 times daily until rash is clear." Resident 12's July 2023 MAR directed administration of this topical medication in the morning, afternoon, and evening.

On 07/19/2023 at 9:21 A.M., Surveyor asked Caregiver II if there were any remaining residents requiring morning blood glucose monitoring and insulin administration. Caregiver II told Surveyor s/he had not administered medications to

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Resident 5 and Resident 10, yet. Caregiver II told Surveyor s/he was unable to start medication administration when s/he arrived on duty on this morning at 6:00 A.M. Caregiver II told Surveyor one of the caregivers on duty during the night shift was unable to assist residents with transfers related to a medical reason. Caregiver II told Surveyor s/he assisted the other night shift caregiver to assist with Resident 5's transfer out of bed and this delayed Caregiver II starting the morning medication pass.

On 07/19/2023 from 9:24 A.M., Surveyor observed as Caregiver II conducted morning medication administration related to Resident 4. Surveyor observed Caregiver II dispense several oral medications into the medication cup before returning the medication bubble packs to the medication cart. During this observation, Surveyor did not observe Caregiver II dispense Resident 4's metformin (oral diabetes medication) tablet and lisinopril (blood pressure medication) tablet, as ordered. Caregiver II told Surveyor s/he was not going to administer Resident 4's lisinopril tablet until after Caregiver II had taken Resident 4's blood pressure. Following administration of the dispensed oral medications to Resident 4 as observed by Surveyor at 9:30 A.M., Caregiver II returned to the cart. Surveyor observed Caregiver II search the medication cart until 9:45 A.M. when Caregiver II asked House Manager EE where Resident 4's wound care supplies were located in the cart. Surveyor observed House Manager EE review Resident 4's electronic MAR and tell Caregiver II Resident 4's home health care services were recently at the facility and s/he would have to check Resident 4's wound care orders. Surveyor observed Caregiver II dispense Resident 4's lisinopril tablet into a medication cup and stand looking at the top of the medication

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cart holding the medication cup. Surveyor asked Caregiver II what s/he was doing. Caregiver II told Surveyor s/he was waiting for House Manager EE to return to the cart because s/he did not want to have to walk to Resident 4 twice. Surveyor observed House Manager EE tell Caregiver II not to wait for House Manager EE while s/he checked on Resident 4's wound care orders. At 9:48 A.M., Surveyor observed Caregiver II take Resident 4's blood pressure and administer Resident 4's lisinopril. Surveyor did not observe Caregiver II administer Resident 4's metformin, as ordered. At approximately 4:00 p.m., Surveyor reviewed the medication cart related to Resident 4's medications with Caregiver KK. Surveyor observed Resident 4's morning metformin medication bubble pack contained the metformin tablet prescribed to be administered on 07/19/2023 in blister #19 (see Photo 18).
Surveyor reviewed Resident 4's demographic data, practitioner's orders, and July 2023 MAR, as received by House Manager EE. Resident 4 was admitted to the facility on 02/16/2021. Resident 4's practitioner's orders included a prescription for metformin 500 mg with meals twice daily. Resident 4's July 2023 MAR directed administration of Resident 4's morning dose of metformin at 8:00 A.M. related to Resident 4's morning meal.

On 07/19/2023 at 9:50 A.M., Surveyor observed as Caregiver II conducted morning medication administration related to Resident 5. Surveyor observed Caregiver II dispense several different oral medications into a medication cup for Resident 5, except furosemide (Lasix; diuretic, water pill) 40 mg and folic acid (vitamin supplement) 1 mg. Surveyor observed Caregiver II place Resident 5's Nyamyc topical, antifungal

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powder on top of the medication cart. Caregiver II told Surveyor s/he was going to administer the oral medications to Resident 5, as dispensed. Surveyor reviewed the medications within the medication cup with Caregiver II and asked if s/he was sure s/he dispensed all of Resident 5's medications, as scheduled to be administered. Surveyor observed Caregiver II remove Resident 5's furosemide bubble pack from the cart and Surveyor observed Resident 5's furosemide tablet remained in Resident 5's blister #19 intended for morning medication pass. Caregiver II said, "I [Caregiver II] probably went past it." Surveyor asked Caregiver II about Resident 5's folic acid dose without a response from Caregiver II. Surveyor asked Caregiver II to review Resident 5's folic acid bubble pack. Surveyor observed Caregiver II remove Resident 5's folic acid bubble pack from the cart and Surveyor observed Resident 5's folic acid partially remained in Resident 5's blister #19 intended for morning medication pass. Surveyor asked Caregiver II twice if Caregiver II could see Resident 5's folic acid partially removed from the blister without a response from Caregiver II. Surveyor observed Caregiver II dispense Resident 5's furosemide and folic acid tablets into the medication cup with the previously dispensed medications. Surveyor observed Caregiver II attempt locate Resident 5's glucometer and glucometer test strips for several minutes. Caregiver II took a test strip from Resident 3's container and attempted to insert it into Resident 5's glucometer without success and return the test strip to Resident 3's container. Surveyor observed Caregiver II ask House Manager GG if there were glucometer tests strips available in the cart for Resident 5. At 10:10 A.M., Surveyor observed Caregiver II return Resident 5's Nyamyc powder to the top drawer of the medication cart. At 10:14 A.M., Surveyor

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SV SOUTH BELOIT TERRACE	2771 IVA COURT BELOIT, WI 53511

(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 205	Continued From page 37 observed Caregiver II remove Resident 5's Humalog insulin (fast-acting insulin to control blood glucose) pen from the cart and approach Resident 5 seated in a recliner located in the facility's front living room area. Resident 5 told Surveyor s/he had eaten breakfast at approximately 7:00 A.M., including a breakfast sandwich and 2 pieces of toast. Surveyor observed Caregiver II administer 3 units of Humalog insulin to Resident 5. Caregiver II told Surveyor s/he could administer Resident 5's Humalog without checking Resident 5's glucose level. At 10:16 A.M., Surveyor observed House Manager FF give Caregiver II an unopened box of glucometer test strips and tell Caregiver II they belonged to Resident 5. Surveyor observed Caregiver II administer Resident 5's oral medications, as dispensed. Surveyor observed Caregiver II return to the medication cart and search the top drawer of the medication cart. At 10:21 A.M., Caregiver II told Surveyor s/he was unable to locate Resident 5's eye drops to be administered during the morning medication pass. At 10:25 A.M., Surveyor observed Caregiver II return to Resident 5 and take Resident 5's blood pressure and pulse. At 10:33 A.M., Surveyor observed Caregiver II return to the medication cart and prepare Resident 5's glucometer. At 10:35 A.M., approximately 20 minutes after Caregiver II administered Resident 3's Humalog insulin, Surveyor observed Caregiver II take Resident 5's blood glucose and the reading was 386. Resident 5 told Surveyor s/he was supposed to have blood glucose checked before s/he eats breakfast and 386 was "pretty high." Resident 5 told Surveyor his/her blood glucose was not monitored prior to eating breakfast on this morning and his/her morning insulin was administered late, after breakfast, and before his/her blood glucose was checked.	N 205		

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N 205	Continued From page 38 Surveyor reviewed Resident 5's demographic data, practitioner's orders, and July 2023 MAR, as received by House Manager EE. Resident 5 was admitted to the facility on 04/19/2019 with diagnoses including diabetes and hypertension. Resident 5's practitioner's orders included a prescription for 3 units of Humalog insulin subcutaneous injection to be administered every morning with breakfast, a prescription for furosemide 40 mg daily for edema (swelling), and a prescription for folic acid 1 mg daily in the morning as a supplement. On 07/19/2023 at 10:55 A.M., Surveyor observed Caregiver II place a Levemir (long-acting insulin) pen syringe in to a small, clear plastic bag containing 2 small containers of nystatin powder (antifungal, topical medication) and labeled with Resident 10's first name. Caregiver II told Surveyor s/he just administered Resident 10's Levemir insulin. Surveyor observed the Levemir pen syringe did not contain a label including Resident 10's name. Surveyor asked Caregiver II how s/he knew the Levemir pen syringe belonged to Resident 10 and why s/he placing the syringe in a bag containing topical medications. Caregiver II told Surveyor s/he found the insulin syringe in the plastic bag and s/he was putting it back where s/he found it. Surveyor reviewed Resident 10's demographic data, practitioner's orders, Resident 10's blood glucose documentation, and July 2023 MAR, as received by House Manager EE. Resident 10 was admitted to the facility on 09/19/2018 and had diagnoses including diabetes. Resident 10's practitioner's orders included a prescription for 10 units of Levemir insulin to be injected subcutaneously 2 times daily for diabetes. The prescription included, "Test blood sugar [glucose] in the morning [and] evening before giving, if	N 205		

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N 205	Continued From page 39	N 205		

blood sugar is under 200, DO NOT GIVE INSULIN." Surveyor reviewed Resident 10's blood glucose monitoring from 06/05/2023 through, and including, Resident 10's blood glucose on 07/19/2023 at 10:53 A.M. of 333. Resident 10's blood glucose reading of 333 was the highest reading in the reviewed timeframe. Resident 10's average of the documented morning blood glucose readings during this timeframe was 145. Several of Resident 10's documented morning blood glucose readings during this timeframe were lower than 200, in which Resident 10 would not have required a morning dose Levemir insulin, as ordered. Most of these documented morning readings of blood glucose lower than 200 were documented as checked between 7:00 A.M. and 9:00 A.M. Resident 10's July 2023 MAR included a directive to administer Resident 10's Levemir insulin at 8:00 A.M. Resident 10's MAR included Caregiver II's documentation of 10 units of Levemir insulin administered to Resident 10 on 07/19/2023 at 10:53 A.M.

On 07/19/2023 at 9:50 A.M., Surveyor observed Resident 15 tell Caregiver II s/he was supposed to have his/her morning medications administered at 8:00 A.M. and s/he wanted the morning medications administered. Surveyor observed Caregiver II did not respond to Resident 15.
At 10:30 A.M., Surveyor observed Resident 15 approach Caregiver II and ask to have his/her morning medications administered.
At 10:57 A.M., Surveyor observed Resident 15 tell Caregiver II in a loud voice it was not okay his/her morning medications were 3 hours late. Surveyor observed Caregiver II tell Resident 15 it was okay. At 10:59 A.M., Surveyor observed Caregiver II dispense and administer Resident

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N 205	Continued From page 40	N 205		

15's prescribed morning medication.
Surveyor reviewed Resident 15's demographic data and July 2023 MAR, as received by House Manager EE. Resident 15 was admitted to the facility on 09/09/2022 with diagnoses including osteoarthritis. Resident 15's July 2023 MAR included prescribed morning medications with a directive to be administered at 8:00 A.M., including acetaminophen (Tylenol) 1000 mg 3 times per day for pain.

On 07/19/2023 at 7:48 A.M., Surveyor observed Resident 18 approach Caregiver II and ask if s/he could have his/her "Miralax [polyethylene glycol; powdered bowel medication] now, I [Resident 18] need it." At 8:02 A.M. and 8:35 A.M., Surveyor observed Resident 18 approach Caregiver II and request his/her Miralax and was told to wait by Caregiver II. At 9:18 A.M., Surveyor observed Resident 18 approach Caregiver II at the medication cart and tell Caregiver II s/he would be in his/her bedroom if Caregiver II could administer his/her Miralax. At 10:32 A.M., Surveyor observed Resident 18 approach Caregiver II and ask to have Miralax administered and Caregiver II told Resident 18 s/he would have to ask House Manager EE about Resident 18's Miralax because Caregiver II did not see it prescribed for Resident 18 on Resident 18's MAR. At 10:59 A.M., Surveyor observed Resident 18 approach Caregiver II and request administration of Miralax and Caregiver II responded, "Just give me a second."
At 1:22 P.M., Surveyor conducted an interview with Resident 18 in his/her room. Resident 18 told Surveyor s/he had his/her last bowel movement on Monday and s/he felt "constipated." Resident 18 told Surveyor Miralax was ordered to be administered every morning and evening on a daily basis. Resident 18 said Caregiver II told

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him/her Caregiver II would administer Resident 18's Miralax "later" when Caregiver II administered Resident 18's other medications early on this morning.
At 3:55 P.M., Caregiver KK and Surveyor reviewed the medication cart and were unable to locate Resident 18's container of Miralax, as prescribed.
Surveyor reviewed Resident 18's demographic data, practitioner's orders, and July 2023 MAR, as received by House Manager EE. Resident 18 was admitted to the facility on 09/09/2022 and had diagnoses including constipation. Resident 18's practitioner's orders included a prescription for 17 grams (one capful) of polyethylene glycol (Miralax powder) to be dissolved in 8 ounces of liquid and administered 2 times per day for constipation. Resident 18's July 2023 MAR included a directive to administer this medication at 7:00 A.M. and included Caregiver II's documentation of administration of this medication to Resident 18 on 07/19/2023 at 6:25 A.M. along with Resident 18's other morning medications directed to be administered at 7:00 A.M.
At 4:01 P.M., House Manager EE told Surveyor s/he ordered a container of polyethylene glycol from the pharmacy, as prescribed, at 11:00 A.M. on this day for Resident 18 because it was not available on the cart to administer to Resident 18 this morning.

On 07/19/2023 at 11:11 A.M., Surveyor conducted an interview with House Manager EE. House Manager EE told Surveyor s/he had to pull Caregiver II from a different facility licensed by Licensee TT to fill an open space on the morning to afternoon shift, 6:00 A.M. to 2:00 P.M. House Manager EE told Surveyor the availability of staff whom work at this facility was low. House

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N 205	Continued From page 42 Manager EE told Surveyor Caregiver II had completed medication administration training, as required, and had completed orientation training at the other facility. On 07/19/2023 at 4:04 P.M., Surveyor conducted an interview with House Manager EE. House Manager EE told Surveyor s/he observed an odor indicative of marijuana whenever s/he approached the medication cart during the morning medication pass conducted by Caregiver II. House Manager EE said the odor of marijuana was strong, obvious and s/he could see Caregiver II had many issues conducting the morning medication pass. House Manager EE told Surveyor s/he had reached out to Administrator DD to discuss House Manager EE's concerns with the odor of marijuana on the medication cart and Caregiver II's behavior during the medication pass. House Manager EE told Surveyor s/he was concerned Caregiver II was under the influence and/or impaired during the morning medication pass. On 07/19/2023 at approximately 6:09 P.M., Surveyor conducted an interview with Administrator DD, House Manager EE, and Administrative Assistant HH. Surveyor discussed Caregiver II's observed behavior, including difficulty reading the MAR and providing appropriate verbal responses, issues conducting morning medication pass, and the odor indicative of marijuana on the medication cart. Administrator DD told Surveyor s/he had recently observed Caregiver II at work and Surveyor's and House Manager EE's description of Caregiver II's behavior during medication pass did not sound like a description of Caregiver II. Administrator DD said it sounded like a completely different person. Administrator DD told Surveyor any	N 205		

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N 205	Continued From page 43 member of management or any caregiver observing an odor of marijuana, or having any concerns regarding an impaired caregiver, the caregiver should have been pulled aside, told about the odor, and told they appeared impaired. The caregiver should have been told s/he would need to be tested for illicit substances and employment terminated if the caregiver refused to be tested or tested positive. Administrator DD said Caregiver II should have been off of the morning medication pass and sent for testing. Surveyor asked why Caregiver II was not pulled from morning medication when the odor and Caregiver II's behaviors were suspected to be related to impairment. House Manager EE said, "I [House Manager EE] was just blown away, my [House Manager EE's] mind was blown." Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0352 DHS 83.32(3)(h) Resident Of Residents: Receive Medications N0431 DHS 83.38(1)(g) Health Monitoring N0441 DHS 83.39(3) Hand Washing	N 205		
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	N 220		

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N 220	Continued From page 44 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 that 3 of 3 employees reviewed were screened by a physician, physician assistant, clinical nurse practitioner, or licensed registered nurse for clinically apparent communicable disease including tuberculosis within 90 days before the start of employment. Caregivers JJ, LL, and MM were not screened for communicable diseases within 90 days before the start of their employment. This requirement is being cited for a second time. See Statement of Deficiency (SOD) 705413, issued 12/01/2022. Findings include: On 07/19/2023, Surveyors conducted a complaint investigation into allegations of employee communicable disease screening. Surveyor conducted a review of 3 employees to verify compliance with communicable disease screening procedures. Surveyor requested communicable disease screens for Caregivers JJ, LL, and MM from House Manager EE. There was no evidence of a screen completed for Caregiver JJ, hired 06/23/2023. At approximately 12:40 p.m., House Manager EE reported s/he was unable to find a screen for Caregiver JJ. The screen for Caregiver LL, hired 07/05/2023,	N 220		

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N 220	Continued From page 45 did not contain evidence of having been completed by a physician, physician assistant, clinical nurse practitioner, or licensed registered nurse. The screen was signed by Caregiver LL. The section of the screen for the medical provider or nurse to indicate their review of the screen document was blank. The screen for Caregiver MM, hired 06/19/2023, did not contain evidence of having been completed by a physician, physician assistant, clinical nurse practitioner, or licensed registered nurse. The screen was signed by Caregiver MM. The section of the screen for the medical provider or nurse to indicate their review of the screen document was blank. A tuberculosis skin test document was attached to the screen showing that the test was administered by Former Licensed Practical Nurse (LPN) K on 06/19/2023, but the section indicating the results of the tuberculosis skin test was blank. On 07/19/2023, at approximately 6:09 p.m., Surveyor interviewed Administrator DD, House Manager EE, and Administrative Assistant HH. House Manager EE confirmed s/he was unable to find any communicable disease screen for Caregiver JJ. Administrator DD reported that the previous administrator or registered nurse were supposed to conduct the employee communicable disease screens but acknowledged that there was no evidence of screens for Caregivers JJ, LL, and MM. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	N 220		

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{N 352}	Continued From page 46	{N 352}		
{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 observation, interview, and record review, the provider did not ensure Resident 5, Resident 10, Resident 14, Resident 11, Resident 12, Resident 18, Resident 4, and Resident 3 received all prescribed medications in the dosages and intervals as prescribed by a practitioner. Resident 5 was administered a dose of prescribed fast-acting insulin on 07/19/2023 with breakfast approximately 3 hours after Resident 5 had eaten breakfast. Resident 5 was administered a dose of fast-acting insulin prescribed for lunch, including 3 additional units based on Resident 5's blood glucose reading was over 200, within approximately 1.5 hours of Resident 5's morning dose of fast-acting insulin. Resident 10's blood glucose level was checked and a prescribed dose of insulin was administered on 07/19/2023 several hours after Resident 10 consumed breakfast. Resident 10's blood glucose level was significantly higher than Resident 10's average morning blood glucose levels. Resident 14 was administered an incorrect dosage of prescribed Symbicort inhaler during the	{N 352}		

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{N 352}	Continued From page 47 morning medication pass on 07/19/2023. Caregiver II did not administer Resident 11's Eliquis (anticoagulation medication), as prescribed, until after Surveyor questioned Caregiver II's process for dispensing medications during observation of the morning medication pass on 07/19/2023. Resident 12 was not administered Nyamyc (antifungal, topical medicated powder) from 07/13/2023 through 07/18/2023, as prescribed. On 07/19/2023 at 12:30 P.M., Caregiver II documented application of Resident 12's Nyamyc powder several hours following the scheduled morning dose. On 07/19/2023, Caregiver II administered Resident 12's dicyclomine (medication used for irritable bowel syndrome) approximately 1.5 hours after Resident 12's breakfast meal, not before as prescribed. Resident 18 did not receive his/her morning dose of Miralax [polyethylene glycol; powdered bowel medication] on 07/19/2023. Resident 4 did not receive his/her morning Metformin or mycostatin powder on 07/19/2023. The holding of Resident 4's Lisinopril on 6 occasions between 06/01/2023 - 07/19/2023 was not based on the order of a medical provider. The holding of Resident 3's blood pressure medication on 3 occasions between 06/01/2023 - 07/19/2023- was not based on the order of a medical provider. On 07/11/2023, Resident 3 was administered the incorrect dosage of sliding scale insulin. This requirement is being cited for the fifth time.	{N 352}		

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{N 352}	Continued From page 48 See Statement of Deficiency (SOD) 705414, issued on 04/14/2023, SOD 705413, issued 12/01/2022, SOD JFZC13, issued 02/17/2021, and SOD RL8X11, issued 06/08/2020. The findings include: On 07/19/2023, Surveyors conducted a complaint investigation and verification visit regarding concerns with medication administration. On 07/19/2023 at 9:21 A.M., Surveyor asked Caregiver II if there were any remaining residents requiring morning blood glucose monitoring and insulin administration. Caregiver II told Surveyor s/he had not administered medications to Resident 5 and Resident 10, yet. Caregiver II told Surveyor s/he was unable to start medication administration when s/he arrived on duty on this morning at 6:00 A.M. Caregiver II told Surveyor one of the caregivers on duty during the night shift was unable to assist residents with transfers related to a medical reason. Caregiver II told Surveyor s/he assisted the other night shift caregiver to assist with Resident 5's transfer out of bed and this delayed Caregiver II starting the morning medication pass. Example 1: Resident 5's fast-acting insulin On 07/19/2023 at 9:50 A.M., Surveyor observed as Caregiver II conducted morning medication administration related to Resident 5. Surveyor observed Caregiver II dispense several different oral medications into a medication cup for Resident 5, except furosemide (Lasix; diuretic, water pill) 40 mg and folic acid (vitamin supplement) 1 mg. Caregiver II told Surveyor s/he was going to administer the oral medications to Resident 5, as dispensed. Surveyor reviewed	{N 352}		

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the medications within the medication cup with Caregiver II and asked if s/he was sure s/he dispensed all of Resident 5's medications, as scheduled to be administered. Surveyor observed Caregiver II remove Resident 5's furosemide bubble pack from the cart and Surveyor observed Resident 5's furosemide tablet remained in Resident 5's blister #19 intended for morning medication pass. Caregiver II said, "I [Caregiver II] probably went passed it." Surveyor asked Caregiver II about Resident 5's folic acid dose without a response from Caregiver II. Surveyor asked Caregiver II to review Resident 5's folic acid bubble pack. Surveyor observed Caregiver II removed Resident 5's folic acid bubble pack from the cart and Surveyor observed Resident 5's folic acid partially remained in Resident 5's blister #19 intended for morning medication pass. Surveyor asked Caregiver II twice if Caregiver II could see Resident 5's folic acid partially removed from the blister without a response from Caregiver II. Surveyor observed Caregiver II dispense Resident 5's furosemide and folic acid tablets into the medication cup with the previously dispensed medications. Surveyor observed Caregiver II attempt to locate Resident 5's glucometer and glucometer test strips for several minutes. Caregiver II took a test strip from Resident 3's container and attempted to insert it into Resident 5's glucometer without success and return the test strip to Resident 3's container. Surveyor observed Caregiver II ask House Manager GG if there were glucometer tests strips available in the cart for Resident 5. At 10:14 A.M., Surveyor observed Caregiver II remove Resident 5's Humalog insulin (fast-acting insulin to control blood glucose) pen from the cart and approach Resident 5 seated in a recliner located in the facility's front living room area. Resident 5 told Surveyor s/he had eaten

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breakfast at approximately 7:00 A.M., including a breakfast sandwich and 2 pieces of toast. Surveyor observed Caregiver II administer 3 units of Humalog insulin to Resident 5. Caregiver II told Surveyor s/he could administer Resident 5's Humalog without checking Resident 5's glucose level. At 10:16 A.M., Surveyor observed House Manager FF give Caregiver II an unopened box of glucometer test strips and tell Caregiver II they belonged to Resident 5. Surveyor observed Caregiver II administer Resident 5's oral medications, as dispensed. Surveyor observed Caregiver II return to the medication cart and search the top drawer of the medication cart. At 10:21 A.M., Caregiver II told Surveyor s/he was unable to locate Resident 5's eye drops to be administered during the morning medication pass. At 10:25 A.M., Surveyor observed Caregiver II return to Resident 5 and take Resident 5's blood pressure and pulse. At 10:33 A.M., Surveyor observed Caregiver II return to the medication cart, prepare Resident 5's glucometer. At 10:35 A.M., approximately 20 minutes after Caregiver II administered Resident 3's Humalog insulin, Surveyor observed Caregiver II take Resident 5's blood glucose and the reading was 386. Resident 5 told Surveyor s/he was supposed to have blood glucose checked before s/he eats breakfast and 386 was "pretty high." Resident 5 told Surveyor his/her blood glucose was not monitored prior to eating breakfast on this morning and his/her morning insulin was administered late, after breakfast, and before his/her blood glucose was checked.
Surveyor observed Resident 5 remain seated in a recliner located in the facility's front living room area until lunch at approximately 12:05 P.M. Surveyor reviewed Resident 5's demographic data, practitioner's orders, and July 2023 medication administration record (MAR), as

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received by House Manager EE. Resident 5 was admitted to the facility on 04/19/2019 with diagnoses including diabetes and hypertension. Resident 5's practitioner's orders included a prescription for 3 units of Humalog insulin subcutaneous injection to be administered every morning with breakfast, 6 units of Humalog insulin subcutaneous injection to be administered with lunch and dinner, and 3 extra units of Humalog with lunch and dinner if Resident 5's blood glucose if over 200.
Resident 5's July 2023 MAR included Caregiver II's documentation of Resident 5's blood glucose reading at 11:58 A.M., just over 1 hour after Caregiver II took Resident 5's morning blood glucose late and after breakfast, and the reading was 327. Resident 5's July 2023 MAR included Caregiver II's documentation of administration Resident 5's lunchtime 6 unit dose of Humalog insulin with an additional 3 units of Humalog insulin because Resident 5's blood glucose remained over 200. The 9 units of Humalog insulin was documented as administered at 11:58 A.M. by Caregiver II, approximately 1.5 hours after Resident 5's morning Humalog insulin was administered late by Caregiver II.
Resident 5's practitioner's orders included a prescription for furosemide 40 mg daily for edema (swelling), and a prescription for folic acid 1 mg daily in the morning as a supplement.

Example 2: Resident 10's insulin administration

On 07/19/2023 at 10:55 A.M., Surveyor observed Caregiver II place a Levemir (long-acting insulin) pen syringe in to a small, clear plastic bag containing 2 small containers of nystatin powder (antifungal, topical medication) and labeled with Resident 10's first name. Caregiver II told Surveyor s/he just checked Resident 10's blood

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glucose, which was 333, and administered Resident 10's morning dose of Levemir insulin. Surveyor observed the Levemir pen syringe did not contain a label including Resident 10's name. Surveyor asked Caregiver II how s/he knew the Levemir pen syringe belonged to Resident 10 and why s/he placing the syringe in a bag containing topical medications. Caregiver II told Surveyor s/he found the insulin syringe in the plastic bag and s/he was putting it back where s/he found it. Caregiver II told Surveyor Resident 10 ate breakfast between 7:00 A.M. and 8:00 A.M. on this morning.
Surveyor reviewed Resident 10's demographic data, practitioner's orders, Resident 10's blood glucose documentation, and July 2023 MAR, as received by House Manager EE. Resident 10 was admitted to the facility on 09/19/2018 and had diagnoses including diabetes. Resident 10's practitioner's orders included a prescription for 10 units of Levemir insulin to be injected subcutaneously 2 times daily for diabetes. The prescription included, "Test blood sugar [glucose] in the morning [and] evening before giving, if blood sugar is under 200, DO NOT GIVE INSULIN." Surveyor reviewed Resident 10's blood glucose monitoring from 06/05/2023 through, and including, Resident 10's blood glucose on 07/19/2023 at 10:53 A.M. of 333. Resident 10's blood glucose reading of 333 was the highest reading in the reviewed timeframe. Resident 10's average of documented morning blood glucose readings during this timeframe was 145. Several of Resident 10's documented morning blood glucose readings during this timeframe were lower than 200, in which Resident 10 would not have required a morning dose Levemir insulin, as ordered. Most of these documented morning readings of blood glucose lower than 200 were documented as checked

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between 7:00 A.M. and 9:00 A.M. Resident 10's July 2023 MAR included a directive to administer Resident 10's Levemir insulin at 8:00 A.M. Resident 10's MAR included Caregiver II's documentation of 10 units of Levemir insulin administered to Resident 10 on 07/19/2023 at 10:53 A.M.

Example 3: Resident 14's respiratory inhaler

On 07/19/2023 at 8:27 A.M., Surveyor observed Resident 14 approach the medication cart in his/her wheelchair. Surveyor observed Resident 14 ask Caregiver II if s/he could be administered his/her inhalers. Surveyor observed Resident 14 state, "I [Resident 14] always get both of my [Resident 14's] inhalers in the morning." Caregiver II told Surveyor s/he already administered one of Resident 14's inhalers earlier in morning. Surveyor observed Caregiver II dispense and hand a Symbicort inhaler [inhaled respiratory medication] to Resident 14, and Surveyor observed Resident 14 administer 1 inhalation of Symbicort to self before handing it back to Caregiver II. Surveyor observed Caregiver II did not observe Resident 14's administration of the inhaler, did not cue Resident 14 to take a second inhalation, as prescribed, and did not document administration of this inhaler in Resident 14's electronic MAR. Surveyor asked Caregiver II at what time Resident 14 was to receive administration of Symbicort inhaler. Caregiver II told Surveyor s/he did not look at Resident 14's MAR to review the orders before s/he dispensed the Symbicort inhaler to Resident 14 and stated, "There is just so much coming at me [Caregiver II]." Surveyor observed Resident 14 continue to sit near the medication cart, looking at Caregiver II as Caregiver II looked at Resident 11's electronic MAR. Surveyor

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{N 352}	Continued From page 54 observed Resident 14 state, "I [Resident 14] can see this is going to take a while" as Resident 14 started to wheel his/her chair away from the medication cart. Surveyor observed Caregiver II announce towards Resident 14, "I [Caregiver II] will get to [administer] the rest of your [Resident 14's] medications later." Surveyor reviewed Resident 14's demographic data, practitioner's orders, and July 2023 MAR, as received by House Manager EE. Resident 14 was admitted to the facility on 01/17/2020 and had diagnoses including chronic obstructive pulmonary disease [COPD]. Resident 14's orders included a prescription for 2 inhalations of Symbicort inhaler twice daily. Resident 14's MAR for 07/19/2023 included Caregiver II's documented administration of Symbicort inhaler to Resident 14 at 11:29 A.M., 2 hours after this medication was administered to Resident 14. Example 4: Resident 11's anticoagulant medication On 07/19/2023 at 8:34 A.M., Surveyor observed as Caregiver II conducted morning medication administration related to Resident 11. Surveyor observed Caregiver II remove Resident 11's bubble packs containing famotidine [Pepcid; gastric reflux medication], Tylenol [acetaminophen], and Eliquis [anticoagulant medication] from the medication cart. Surveyor observed Caregiver II dispense 1 half of a tablet of famotidine and two tablets of Tylenol into a medication cup. Surveyor did not observe Caregiver II dispense Eliquis into the medication cup before returning all three bubble packs to the medication cart. Caregiver II told Surveyor s/he was going to administer the medications to Resident 11, as dispensed. Surveyor reviewed the medications within the	{N 352}		

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medication cup with Caregiver II and asked if s/he was sure s/he dispensed all of Resident 11's medications, as scheduled to be administered. Caregiver II said, "I [Caregiver II] thought I [Caregiver II] popped out all of them out [of Resident 11's bubble packs]." Surveyor observed Caregiver II remove the same three bubble packs from the medication cart for a second time. Surveyor observed Caregiver II find a small, white, loose tablet at the bottom of the medication drawer and place it within the medication cup containing other medications dispensed for Resident 11. Surveyor asked Caregiver II if s/he was sure that medication was Resident 11's Eliquis. Caregiver II reviewed the medications in the cup and compared them to the pictures included in Resident 11's electronic MAR. Caregiver II told Surveyor s/he realized Resident 11's Eliquis medication was tan/pink in color and was not included in the medications s/he had dispensed. Surveyor observed Caregiver II remove the small, white tablet s/he found at the bottom of the cart and place it in a separate medication cup. Caregiver II gave that separate medication cup to House Manager GG and told him/her s/he found the tablet at the bottom of the cart and it needed to be destroyed. Surveyor observed Caregiver II dispense Resident 11's Eliquis from the bubble pack and add it to the other medications dispensed for Resident 11 before administering the medications to Resident 11.

Surveyor reviewed Resident 11's demographic data, practitioner's orders, and July 2023 MAR, as received by House Manager EE. Resident 11 was admitted to the facility on 05/03/2022. Resident 11's practitioner's orders and July 2023 MAR included a prescription for Eliquis 5 mg to be administered by mouth twice daily for deep vein thrombosis and pulmonary embolism, both

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{N 352}	Continued From page 56 potentially life threatening diagnoses. Example 5: Resident 12's topical antifungal medication On 07/19/2023 from 8:59 A.M. until approximately 9:23 A.M., Surveyor observed as Caregiver II conducted morning medication administration related to Resident 12. Surveyor observed Caregiver II dispense several different oral medications into a medication cup for Resident 12, including dicyclomine (medication used for irritable bowel syndrome) 10 mg. Surveyor observed Caregiver II remove Resident 12's Nyamyc antifungal, topical powder container from the medication cart. At 9:10 A.M., Surveyor observed Caregiver II administer Resident 12's oral medications to Resident 12 seated in a wheelchair located in Resident 12's bedroom. Following administration of Resident 12's oral medications, Surveyor observed Caregiver II ask Resident 12 if there was anywhere s/he wanted the Nyamyc antifungal, topical powder to be applied and if Resident 12 itched anywhere. Surveyor observed Resident 12 tell Caregiver II "No." Caregiver II told Surveyor s/he did not know where the Nyamyc powder was to be applied and left Resident 12's room without administration of Nyamyc powder, as ordered, and returned to the medication cart. Caregiver II told Surveyor Resident 12 had eaten breakfast at approximately 7:40 A.M. earlier that morning, over an hour before Resident 12 was administered dicyclomine by Caregiver II. At the medication cart, Surveyor asked House Manager EE about Resident 12's order for Nyamyc powder. House Manager EE told Surveyor Resident 12 had a new, red, raw rash identified to Resident 12's groin area approximately 1 week ago on 07/13/2023. House	{N 352}		

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{N 352}	Continued From page 57 Manager EE told Caregiver II it was not enough to ask Resident 12 if /she had an itchy area in order to determine application. Surveyor observed House Manager EE tell Caregiver II to check Resident 12's rash and apply Resident 12's Nyamyc powder to Resident 12's groin the next time Caregiver II assisted Resident 12 with toileting and document in Resident 12's MAR after administered. Surveyor reviewed Resident 12's demographic data, practitioner's orders, and July 2023 MAR, as received by House Manager EE. Resident 12 was admitted to the facility on 09/16/2013. Resident 12's practitioner's orders and July 2023 MAR included a prescription for dicyclomine 10 mg to be administered "...by mouth twice a day before meals for IBS [irritable bowel syndrome]." Resident 12's July 2023 MAR directed administration related to Resident 12's morning and evening meals. Resident 12's practitioner's order, dated 07/13/2023, and July 2023 MAR included a prescription for Nyamyc to be applied "..topically to affected area 3 times daily until rash is clear" starting on 07/13/2023. Resident 12's July 2023 MAR directed administration of Nyamyc powder in the morning (at 8:00 A.M.), afternoon, and evening. Resident 12's July 2023 MAR included no documentation of administration of Nyamyc from 07/13/2023 until 07/18/2033 at 12:54 P.M. and 1:42 P.M. where the documentation included, "on order" for both times. Resident 12's July 2023 MAR included administration of Nyamyc on 07/18/2023 at 7:35 P.M. and 07/19/2023 at 12:30 P.M. in the morning medication pass section of 8:00 A.M. At 4:01 P.M., House Manager EE and Surveyor reviewed Resident 12's July 2023 MAR and House Manager EE told Surveyor s/he did not believe Caregiver EE administered Resident 12's Nyamyc powder at 12:30 P.M. on 07/19/2023	{N 352}		

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{N 352}	Continued From page 58 because it was lunch time and the circumstances surrounding Caregiver II performance during the morning's medication pass. House Manager EE said if Caregiver II did administer Resident 12's Nyamyc powder at 12:30 P.M., it was several hours overdue. House Manager EE told Surveyor Resident 12 should have been administered dicyclomine, as ordered, before Resident 12's breakfast. Example 6: Resident 18's bowel medication On 07/19/2023 at 7:48 A.M., Surveyor observed Resident 18 approach Caregiver II and ask if s/he could have his/her "Miralax [polyethylene glycol; powdered bowel medication] now, I [Resident 18] need it." At 8:02 A.M. and 8:35 A.M., Surveyor observed Resident 18 approach Caregiver II and request his/her Miralax and was told to wait by Caregiver II. At 9:18 A.M., Surveyor observed Resident 18 approach Caregiver II at the medication cart and tell Caregiver II s/he would be in his/her bedroom if Caregiver II could administer his/her Miralax. At 10:32 A.M., Surveyor observed Resident 18 approach Caregiver II and ask to have Miralax administered and Caregiver II told Resident 18 s/he would have to ask House Manager EE about Resident 18's Miralax because Caregiver II did not see it prescribed for Resident 18 on Resident 18's MAR. At 10:59 A.M., Surveyor observed Resident 18 approach Caregiver II and request administration of Miralax and Caregiver II responded, "Just give me a second." At 1:22 P.M., Surveyor conducted an interview with Resident 18 in his/her room. Resident 18 told Surveyor s/he had his/her last bowel movement on Monday and s/he felt "constipated." Resident 18 told Surveyor Miralax was ordered to be administered every morning and evening on a	{N 352}		

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{N 352}	Continued From page 59 daily basis. Resident 18 said Caregiver II told him/her Caregiver II would administer Resident 18's Miralax "later" when Caregiver II administered Resident 18's other medications early on this morning. At 3:55 P.M., Caregiver KK and Surveyor reviewed the medication cart and were unable to locate Resident 18's container of Miralax, as prescribed. Surveyor reviewed Resident 18's demographic data, practitioner's orders, and July 2023 MAR, as received by House Manager EE. Resident 18 was admitted to the facility on 09/09/2022 and had diagnoses including constipation. Resident 18's practitioner's orders included a prescription for 17 grams (one capful) of polyethylene glycol (Miralax powder) to be dissolved in 8 ounces of liquid and administered 2 times per day for constipation. Resident 18's July 2023 MAR included a directive to administer this medication at 7:00 A.M. and included Caregiver II's documentation of administration of this medication to Resident 18 on 07/19/2023 at 6:25 A.M. along with Resident 18's other morning medications directed to be administered at 7:00 A.M. On 07/19/2023 at 4:01 P.M., House Manager EE told Surveyor s/he ordered a container of polyethylene glycol from the pharmacy, as prescribed, at 11:00 A.M. on this day for Resident 18 because it was not available on the cart to administer to Resident 18 this morning. Example 7: Resident 4's Metformin & mycostatin powder not administered On 07/19/2023, from 9:24 A.M. until approximately 9:48 A.M., Surveyor observed	{N 352}		

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{N 352}	Continued From page 60 Caregiver II conducting the morning medication pass. Surveyor observed Caregiver II dispense and administer Resident 4 prescribed oral medications, except Resident 4's metformin dose. During this observation timeframe, Caregiver II did not administer any non-oral medications to Resident 4. At approximately 9:45 a.m., Surveyor interviewed Resident 4. Surveyor observed that Resident 4 utilized a manual wheelchair for ambulation. Resident 4 confirmed that s/he only utilizes a wheelchair to get around and that s/he spends most of his/her day either in his/her wheelchair or his/her recliner, which s/he sleeps in. Resident 4 reported s/he had returned from the hospital late last night and that s/he had been initially sent out due to his/her catheter bag leaking and his/her catheter tubing having fell out. While observing Resident 4's room, Surveyor observed an incontinence pad in Resident 4's recliner. At approximately 3:30 p.m., Surveyor interviewed Resident 4 again. In discussing Resident 4's catheter, s/he reported that his/her catheter tubing frequently gets dislodged from its origin. S/he reported that staff say s/he sometimes pulls on it, which causes it to dislodge. Resident 4 reported that s/he has had to go to the emergency department approximately 4-5 times in the last few months due to needing his/her catheter reinserted. According to the National Institutes of Health (NIH), people "who have problems controlling their urine or bowels (called incontinence) are at risk for skin problems. The skin areas most affected are near the buttocks, hips, genitals, and between the pelvis and rectum (perineum). Excess moisture in these areas makes skin	{N 352}		

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{N 352}	Continued From page 61 problems such as redness, peeling, irritation, and yeast infections likely." Excess skin moisture can be treated with an antifungal powder, such as nystatin or miconazole (Source: National Institutes of Health: National Library of Medicine, Skin Care and Incontinence, February 18, 2022, https://medlineplus.gov/ency/article/003976.htm (retrieval date - July 21, 2023).). At approximately 4:00 p.m., Surveyor reviewed the medication cart with Caregiver KK. Surveyor observed Resident 4's Metformin medication card. The pharmacy label on the card indicated that Resident 4 was to take 1 tablet by mouth twice daily, and that the card was his/her morning medication card. Surveyor observed that the individual pack for that morning's Metformin still contained its tablet (see Photo 18). On 07/19/2023, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 02/16/2021 with diagnoses including type 2 diabetes mellitus and unspecified urinary incontinence. Resident 4 has a suprapubic catheter. Resident 4's prescriptions include the following: - Metformin HCl 500 mg tablet: 1 tablet twice daily with meals - Nyamyc 100,000 units/gram powder (mycostatin powder): Apply topically to affected areas twice daily Surveyor reviewed Resident 4's medication administration record (MAR) for July 2023 and observed that Caregiver II signed off on administering Resident 4 his/her Metformin at 11:25 a.m. and his/her mycostatin powder at 11:25 a.m.	{N 352}		

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{N 352}	Continued From page 62 At approximately 4:45 p.m., Surveyor interviewed House Manager EE. House Manager EE acknowledged Surveyor's concern that Resident 4 did not seem to receive his/her prescribed mycostatin powder or Metformin based on Surveyor's observations, despite Caregiver II having signed off as administering it. House Manager EE reported that s/he noticed the morning medication pass with Caregiver II did not go well, and s/he had informed Administrator DD about several issues that s/he identified with Caregiver II's medication pass. Example 8: Resident 4's Lisinopril holding On 07/19/2023, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 02/16/2021 with diagnoses including hypertension. Resident 4 was prescribed Lisinopril 5 mg tablet with the following instructions: "Take 1 tablet by mouth daily for hypertension. Update [medical doctor] if systolic [blood pressure] less than 110 or greater than 180, diastolic less than 55 or greater than 100 and pulse less than 55, or greater than 120 [beats per minute]." Surveyor reviewed Resident 4's MAR from 06/01/2023 - 07/19/2023 and observed the following 6 occurrences in which staff documenting holding Resident 4's Lisinopril due to "no pass per vital parameters": - 06/01/2023 - 06/05/2023 - 06/07/2023 - 06/08/2023 - 06/10/2023 - 06/11/2023	{N 352}		

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{N 352}	Continued From page 63 At approximately 4:45 p.m., Surveyor interviewed House Manager EE. House Manager EE confirmed Surveyor's observations that Lisinopril holding parameters did not appear to be documented as part of Resident 4's physician order. House Manager EE acknowledged Surveyor's concern that staff were using Resident 4's medical provider notification parameters as a medication hold parameter. House Manager EE reported s/he typically reached out to residents' medical providers about parameter-based medications for specific hold parameters, but s/he was fairly new to filling in to this facility and had not yet had a chance to reach out to Resident 4's medical provider to obtain hold parameters. Example 9: Resident 3's blood pressure medications and insulin On 07/19/2023, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 10/13/2021 with diagnoses including diabetes mellitus type II and essential hypertension. Resident 3's prescriptions include the following: - Amlodipine 10 mg tablet: "Take 1 tablet by mouth daily for [hypertension]. Update [medical doctor] if systolic [blood pressure] less than 110 or greater than 180, diastolic less than 55 or greater than 100 and pulse less than 55, or greater than 120 [beats per minute]." - Losartan 100 mg tablet: "Take 1 tablet by mouth daily for hypertension. Update [medical doctor] if systolic [blood pressure] less than 110 or greater than 180, diastolic less than 55 or greater than 100 and pulse less than 55, or greater than 120 [beats per minute]." - Metoprolol succinate extended release 25 mg	{N 352}		

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{N 352}	Continued From page 64	{N 352}		

tablet: "Take 1 tablet by mouth daily for hypertension. Update [medical doctor] if systolic [blood pressure] less than 110 or greater than 180, diastolic less than 55 or greater than 100 and pulse less than 55, or greater than 120 [beats per minute]."

- Novolog FlexPen: "Inject subcutaneously 3 times daily prior to meals per [sliding scale]: less than 150 = 0 units; 151-200 = 2; 201-250 = 4; 251-300 = 6; 301-350 = 8; 351-400 = 10; 401-450 = 14; 451-500 = 16. Over 450, call."

Surveyor reviewed Resident 3's MAR from 06/01/2023 - 07/19/2023 and observed the following 3 occurrences in which staff documenting holding Resident 4's blood pressure medication due to "no pass per vital parameters":

- 06/11/2023: Amlodipine and Metoprolol
- 06/16/2023: Amlodipine
- 07/04/2023: Losartan

Surveyor also observed that on 07/11/2023, at 4:16 p.m., Resident 3's blood sugar was recorded as 220 and 6 units of insulin were documented as administered (despite his/her blood sugar being within the parameters for 4 units).

At approximately 4:45 p.m., Surveyor interviewed House Manager EE. House Manager EE confirmed Surveyor's observations that holding parameters did not appear to be documented as part of the medical provider order for any of Resident 3's blood pressure medications. House Manager EE acknowledged Surveyor's concern that staff were using Resident 3's physician notification parameters as a medication hold parameter. House Manager EE reported s/he typically reached out to residents' medical

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{N 352}	Continued From page 65 providers about parameter-based medications for specific hold parameters but s/he was fairly new to filling in to this facility and had not yet had a chance to reach out to Resident 3's medical provider to obtain hold parameters. House Manager EE confirmed Surveyor's observation that Resident 3 appeared to receive the incorrect amount of sliding scale insulin for his/her 07/11/2023 suppertime administration but said nothing further. Summary: The provider did not ensure Resident 5, Resident 10, Resident 14, Resident 11, Resident 12, Resident 18, Resident 4, and Resident 3 received all prescribed medications in the dosages and intervals as prescribed by a practitioner. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0205 DHS 83.14(2)(i) Not Permit A Condition Of Risk N0441 DHS 83.39(3) Hand Washing	{N 352}		
{N 388}	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review, observation, and interview, the provider did not ensure that the individual service plan (ISP) was followed as written for Resident 4. Resident 4's ISP directed staff to document daily urine color and urine output recording, which was	{N 388}		

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{N 388}	Continued From page 66 not followed on 1 of 6 applicable days and 5 of 18 applicable days, respectively. Resident 4's ISP also directed staff to flush his/her catheter twice daily and change his/her night catheter bag to a leg bag daily, which was not followed on 07/19/2023 during the survey period. This requirement is being cited for the fifth time. See Statement of Deficiency (SOD) 705414, issued 04/14/2023, SOD 705411, issued 01/13/2022, SOD JFZC13, issued 02/17/2021, and SOD RL8X11, issued 06/08/2020. Findings include: On 07/19/2023, at approximately 8:52 a.m., Surveyor observed Resident 4 self-propelling his/her manual wheelchair from the kitchen to the outdoor patio. Surveyor observed that Resident 4 had a catheter bag hooked onto the wheelchair. At approximately 9:45 a.m., Surveyor interviewed Resident 4, and observed that Resident 4 had the same catheter bag as observed earlier. Resident 4 reported s/he had a leg catheter bag that typically is put on by staff in the morning, and a larger bag that is put on at night. Resident 4 confirmed that the bag s/he was currently wearing was his/her night bag. Resident 4 reported s/he wasn't sure why his/her leg bag wasn't on but that s/he liked it better than his/her current bag (the night bag). Resident 4 denied that staff offered him/her the opportunity to change into his/her leg bag yet. At approximately 10:07 a.m., Surveyor observed Resident 4 propel his/her wheelchair from the outdoor patio back inside. S/he still had his/her night catheter bag, which was observed in a blue-toned cloth case. The cloth case containing	{N 388}		

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{N 388}	Continued From page 67 the bag appeared to be dragging on the ground. At approximately 10:45 a.m., Surveyor observed Resident 4 propel his/her wheelchair back outside to the patio. The cloth case, containing his/her night catheter bag, was observed dragging on the floor. At approximately 10:50 a.m., Surveyor observed House Manager GG adjusting Resident 4's bag so that it no longer sat on the ground. At approximately 4:30 p.m., Surveyor interviewed Resident 4 again. Surveyor observed that Resident 4 still had his/her night bag on. Resident 4 confirmed that staff had still not offered him/her an opportunity to change into his/her leg bag. Resident 4 reported s/he felt bad if s/he had to ask staff to change it because staff get busy and things get hectic. Surveyor observed Resident 4's room and bathroom during this time and did not observe his/her leg bag. Surveyor then asked Resident 4 about his/her catheter flushing/irrigation procedure. Resident 4 replied that approximately every 10-14 days staff flushed his/her catheter with vinegar and water. Resident 4 confirmed that his/her catheter was not flushed yet that day and stated, "I know they don't do it every day." From the time Surveyors were on site, at 7:34 a.m., until exiting with House Manager EE, Administrator DD, and Administrative Assistant HH at 6:09 p.m., Surveyors did not observe Resident 4's catheter having been flushed. On 07/19/2023, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 02/16/2021 with diagnoses including spastic hemiplegia, other paralytic syndrome, and unspecified urinary incontinence. Resident 4 was documented as being under guardianship.	{N 388}		

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{N 388}	Continued From page 68	{N 388}		

Resident 4 also has a suprapubic catheter. A communication note in Resident 4's record indicated that Resident 4's initial home health evaluation was completed on 07/13/2023, but that the next follow-up visit was estimated to occur on 08/07/2023. Surveyor reviewed Resident 4's ISP, last signed as reviewed on 10/19/2022, which documented the following:

- Under the "[Change of condition]" section, it states that "[Registered Nurse] from [home health company] has requested daily observation and documentation of urine color ..."
- Under the "Toileting - catheter" section, it states, "Emptying and recording of output. Changing from night bag to leg bag daily. Staff to flush (irrigate the catheter 2x daily) Solution mix of 5% vinegar to 250 mL of distilled water. Fill syringe and irrigate catheter ...Resident requires full assistance from Team Member for Recording[sic] Resident's output through the catheter to ensure no blockage or retention ..."

Surveyor then reviewed Resident 4's observation notes from 06/01/2023 - 07/19/2023, and observed the following:

- Urine color documentation: From 07/13/2023 (home health initiation) - 07/18/2023, urine color was documented on 1 of 6 days. On 07/13/2023, the only day of urine color documentation, Resident 4 was documented as having "extremely dark urine."
- Output recording: Documented on 07/01/2023

Surveyor then reviewed Resident 4's "Care History" document from 07/01/2023 - 07/18/2023, where staff also appeared to document his/her urine output. Between this document and his/her observation notes which documented output on

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{N 388}	Continued From page 69 07/01/2023, the following 5 days contained no evidence of urine output documentation: 07/02/2023, 07/03/2023, 07/09/2023, 07/10/2023, and 07/11/2023. On 07/19/2023, at approximately 4:45 p.m., Surveyor interviewed House Manager EE. House Manager EE confirmed that if urine color and output were not documented in the observation notes or care history that staff were likely not recording it anywhere else. House Manager EE reported s/he thought there was some sort of issue with Resident 4's catheter yesterday but that his/her leg bag should have been in his/her shower. House Manager EE acknowledged Surveyor's concern that staff did not seem to be flushing/irrigating Resident 4's catheter as often as directed in his/her ISP but reported s/he was unaware of any previous issues of staff completing this. House Manager EE then observed Resident 4's bathroom with Surveyor. Surveyor observed House Manager EE open the cabinet underneath the bathroom sink and inspect a leg bag that was sitting in a basket. The leg bag still had traces of liquid, consistent with urine in appearance, throughout the bag. House Manager EE reported s/he wasn't sure if this was Resident 4's current leg bag or if it was an old one but acknowledged that staff did not appear to be cleaning it thoroughly. N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	{N 388}		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of	N 415		

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medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure caregivers appropriately documented medication administration in the medication administration records (MARs) for Resident 3, Resident 4, and Resident 14.

Resident 3's MAR from 06/01/2023 - 07/18/2023 contained 17 blank entries across 9 days.

Resident 4's MAR from 06/01/2023 - 07/18/2023 contained 10 blank entries across 7 days.

Despite the completion of Resident 14's Augmentin [oral antibiotic medication] administration on 07/17/2023, as ordered, Caregiver II documented administration of this medication on 07/19/2023 at 11:28 A.M.

This requirement is being cited for the fifth time. See Statement of Deficiency (SOD) SOD JFZC13, issued 02/17/2021, SOD JFZC12, issued 09/29/2020, SOD JFZC11, issued 07/21/2020, and SOD RL8X11, issued 06/08/2020.

The findings include:

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N 415	Continued From page 71 On 07/19/2023, Surveyors conducted a complaint investigation and verification visit regarding concerns with medication administration management. Example 1: Resident 3 On 07/19/2023, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 10/13/2021 with diagnoses including diabetes mellitus type II, anxiety disorder, and unspecified osteoarthritis. Resident 3's prescriptions include the following: - Acetaminophen 325 mg tablet: 2 tablets 4 times daily - Buspirone HCl 5 mg tablet: 1 tablet 3 times daily - Basaglar 100 unit/mL KwikPen (Lantus Solostar 100 units/mL): 18 units at bedtime - Diclofenac sodium 1% gel: 4 grams topically to lower back 4 times daily - Naproxen 500 mg tablet: 1 tablet twice daily - Prednisone 10 mg tablet: 1 tablet daily Surveyor reviewed Resident 3's MAR from 06/01/2023 - 07/18/2023 and observed the following 17 blank entries across 9 days: - 06/12/2023: Basaglar injection - 07/04/2023: Naproxen tablet - 07/05/2023: Prednisone tablet - 07/06/2023: Prednisone tablet - 07/07/2023: Acetaminophen tablet (7:30 p.m.), Diclofenac sodium gel (7:30 p.m.), and naproxen tablet (8:00 p.m.) - 07/09/2023: Diclofenac sodium gel (12:00 p.m.) - 07/12/2023: Basaglar injection, Acetaminophen tablet (7:30 p.m.), Diclofenac sodium gel (7:30 p.m.) and naproxen tablet (8:00 p.m.)	N 415		

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N 415	Continued From page 72 - 07/13/2023: Buspirone HCl tablet and Naproxen tablet (8:00 p.m.) - 07/16/2023: Acetaminophen tablet (7:30 p.m.), Diclofenac sodium gel (7:30 p.m.), and naproxen tablet (8:00 p.m.) On 07/19/2023, at approximately 4:45 p.m., Surveyor interviewed House Manager EE. House Manager EE reported having noticed MAR documentation issues which s/he thought was due to high staff turnover. Example 2: Resident 4 On 07/19/2023, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 02/16/2021 with diagnoses including major depressive disorder, hyperlipidemia, epilepsy, and unspecified urinary incontinence. Resident 4's prescriptions include the following: - Atorvastatin 20 mg tablet: 1 tablet daily - Buspirone HCl 7.5 mg tablet: 1 tablet twice daily - Divalproex sodium 500 mg tablet: 1 tablet twice daily - Lisinopril 5 mg tablet: 1 tablet daily - Nyamyc 100,000 units/gram powder (mycostatin powder): Apply to affected area twice daily Surveyor reviewed Resident 4's MAR from 06/01/2023 - 07/18/2023 and observed the following 10 blank entries across 7 days: - 06/11/2023: Nighttime mycostatin powder application - 06/12/2023: Nighttime mycostatin powder application - 06/15/2023: Atorvastatin tablet, nighttime Divalproex tablet, nighttime Buspirone tablet, nighttime mycostatin powder application	N 415		

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SV SOUTH BELOIT TERRACE	2771 IVA COURT BELOIT, WI 53511

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N 415	Continued From page 73 - 06/16/2023: Morning mycostatin powder application - 07/09/2023: Lisinopril tablet - 07/11/2023: Nighttime mycostatin powder application - 07/13/2023: Lisinopril tablet On 07/19/2023, at approximately 4:45 p.m., Surveyor interviewed House Manager EE. House Manager EE reported having noticed MAR documentation issues which s/he thought was due to high staff turnover. Example 3: Resident 14's antibiotic medication On 07/19/2023 at 8:27 A.M., Surveyor observed Resident 14 approach the medication cart in his/her wheelchair. Surveyor observed Resident 14 ask Caregiver II if s/he could be administered his/her inhalers. Surveyor observed Caregiver II dispense and hand a Symbicort inhaler [inhaled respiratory medication] to Resident 14, and Surveyor observed Resident 14 administer the inhaler to self before handing it back to Caregiver II. Surveyor observed Resident 14 continue to sit near the medication cart, looking at Caregiver II as Caregiver II looked at the next resident's, Resident 11's, electronic MAR. Surveyor observed Resident 14 state, "I [Resident 14] can see this is going to take a while" as Resident 14 started to wheel his/her chair away from the medication cart. Surveyor observed Caregiver II announce towards Resident 14, "I [Caregiver II] will get to [administer] the rest of your [Resident 14's] medications later." At 11:32 A.M., Resident 14 approached Surveyor and stated, "I [Resident 14] just got my [Resident 14's] morning medications from [Caregiver II]." Surveyor reviewed Resident 14's demographic	N 415		

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N 415	Continued From page 74 data, practitioner's orders, and July 2023 MAR, as received by House Manager EE. Resident 14 was admitted to the facility on 01/17/2020 and had diagnoses including chronic obstructive pulmonary disease [COPD]. Resident 14's orders included a prescription for Augmentin [oral antibiotic medication] 1 tablet to be administered to Resident 14 by mouth every 12 hours for 10 days, dated 07/07/2023. Resident 14's MAR for July 2023 included administration of Resident 14's Augmentin prescription was started on the morning of 07/08/2023 and should have concluded after 10 days of administration on the evening of 07/17/2023. A caregiver documented administration of Augmentin to Resident 14 on 07/18/2023 at 9:38 A.M. and a caregiver documented "No pass reason: Done taking antibiotics." Despite the completion of Resident 14's Augmentin administration, as ordered, Caregiver II documented administration of this medication on 07/19/2023 at 11:28 A.M. Summary: The provider did not ensure caregivers appropriately documented medication administration in the medication administration records (MARs) for Resident 3, Resident 4, and Resident 14. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0205 DHS 83.14(2)(i) Not Permit A Condition Of Substantial Risk N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medications	N 415		
{N 425}	83.38(1)(a) Personal care.	{N 425}		

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{N 425}	Continued From page 75 As appropriate, the CBRF shall teach residents 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: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Resident 17 and Resident 4 were provided with personal care services adequate to meet their individual needs. Resident 17 was not provided with personal care services related to physical transfers resulting in significant injury. Resident 17 was dependent on caregivers to provide assistance with all transfers related, in part, to Resident 17's history of left-sided paralysis. Resident 17's assistive devices to be utilized during transfers included a walker. On 06/16/2023, an agency caregiver new to Resident 17 attempted to transfer Resident 17 from Resident 17's wheelchair to a shower chair located in Resident 17's bathroom. The caregiver did not lock the wheels of Resident 17's wheelchair, attempted to transfer Resident 17 by lifting under Resident 17's left, paralyzed arm, did not ensure Resident 17 utilized a walker, and did not ensure Resident 17 was wearing appropriate footwear during the transfer. Resident 17 fell to	{N 425}		

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{N 425}	Continued From page 76	{N 425}		

the floor when Resident 17's left foot became caught on a floor mat in the bathroom and the caregiver let go of Resident 17. Resident 17 was hospitalized from 06/16/2023 through 06/26/2023 before being admitted to a skilled nursing rehabilitation facility with diagnoses including left ankle fracture and requiring a mechanical lift for all transfers.

Resident 4 had a medical provider order for his/her post-surgical right posterior thigh wound bandage to be changed "as directed", and this was not consistently followed from 06/01/2023 - 07/19/2023. Resident 4's dressing was not changed approximately 8 total times that it was due, including during the survey.

This requirement is being cited for the second time. See SOD 705414, issued on 04/14/2023.

The findings include:

On 07/19/2023, with information gathered through 08/03/2023, Surveyors conducted a complaint investigation alleging concerns with personal care services.

Definitions:
DHS 83.02(37) "Personal care" means assistance with activities of daily living, but does not include nursing care.
DHS 83.02(3) "Activities of daily living" means bathing, eating, oral hygiene, dressing, toileting and incontinence care, mobility, and transferring from one surface to another such as from a bed to a chair.

Example 1: Resident 17's assisted fall incident resulting in significant injury and hospitalization

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{N 425}	Continued From page 77 On 06/28/2023, the department received an "Assisted Living Facility Self-Report" document from Administrator DD. The documentation included an "injury requiring medical assistance" on "06/16/2023 at 12:34 A.M. [sic]." The documentation included, "[Agency Caregiver PP] was transferring [Resident 17] from the wheelchair to the toilet when [Resident 17] lost [his/her] footing and twisted [his/her] ankles as [s/he] tried to reposition. [Resident 17] had complaints of pain in [his/her] ankles. [Agency Caregiver PP] had [Caregiver QQ] assess and call EMTs [emergency medical technician's] due to pain." The documentation included, "[Resident 17] was transported to the hospital. Xrays showed fracture in both ankles" and "[Resident 17] will stay at hospital until released to rehab [skilled nursing facility rehabilitation]." On 07/19/2023 at 2:59 P.M., Surveyor conducted an interview with Administrative Assistant HH. Administrative Assistant HH told Surveyor s/he was at the facility working on the facility's grocery order when Resident 17's fall incident occurred on Friday, 06/16/2023. Administrative Assistant HH and Surveyor reviewed the facility's staffing schedule for 06/16/2023. The facility's staffing schedule for 06/16/2023 included House Manager FF and House Manager EE listed for "[6:00 A.M. to 2:00 P.M.]," Agency Caregiver PP was listed for "[6:00 A.M. to 2:00 P.M. Medication Pass]," and "Former Caregiver RR was listed for [6:00 A.M. to 2:00 P.M. Medication Pass]." Administrative Assistant HH told Surveyor Caregiver QQ worked the night shift leading into the day shift of 06/16/2023 because Former Caregiver RR "called-in" off for the day shift and Caregiver QQ was mandated to stay through the day shift to cover Former Caregiver RR's absence. Administrative Assistant HH said this	{N 425}		

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{N 425}	Continued From page 78	{N 425}		

change in staffing was not documented on the facility's schedule.
Administrative Assistant HH told Surveyor Agency Caregiver PP went to assist Resident 17 with a shower during the day shift on 06/16/2023 without another caregiver to assist before coming out of Resident 17's room and announced both s/he and Resident 17 fell in Resident 17's bathroom. Administrative Assistant HH said Resident 17's left foot got stuck behind him/her and both s/he and Agency Caregiver PP went down to the floor. Administrative Assistant HH said House Manager FF, House Manager EE, and House Manager GG arrived at the facility after Resident 17's incident and called the paramedics to transfer Resident 17 from the floor. Administrative Assistant HH said Resident 17 was transported to a local emergency room due to injury.
Administrative Assistant HH told Surveyor Resident 17 required the assistance of one caregiver with pivot transfers and was more comfortable with caregivers s/he knew. Administrative Assistant HH said Agency Caregiver PP was employed by an agency service and the first time s/he met Agency Caregiver PP was on 06/16/2023. Administrative Assistant HH said Agency Caregiver PP should have documented the incident in Resident 17's record.

On 07/19/2023 at 4:04 P.M., Surveyor conducted an interview with House Manager EE. House Manager EE told Surveyor s/he always observed two caregivers assist Resident 17 transfer to bed and all other transfers to and from the toilet and Resident 17's wheelchair were with one caregiver's assistance. House Manager EE said Resident 17 experienced left-sided weakness and a gait belt should have been utilized during Resident 17's transfers. House Manager EE said

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{N 425}	Continued From page 79 s/he arrived at the facility after Resident 17's fall incident on 06/16/2023 and observed Resident 17 on the floor of his/her bathroom. House Manager EE said s/he did not observe a gait belt on Resident 17's body. House Manager EE said s/he was told Agency Caregiver PP was the only caregiver assisting Resident 17 transfer from the wheelchair to the shower chair when Resident 17's "bad [paralyzed]" left foot got caught and both Resident 17 and Agency Caregiver PP fell to the floor. House Manager EE said Resident 17 was currently residing at a local skilled nursing facility for physical therapy and remained alert, oriented, and capable of making decisions on his/her own behalf. On 07/19/2023, Surveyor received a copy of Resident 17's demographic information, including diagnoses, Resident 17's practitioner's medication orders, Resident 17's individual service plan (ISP), and caregiver documentation. Resident 17 was admitted to the facility on 10/11/2022 with diagnoses including cerebral infarction (ischemic stroke), cramp and spasm, hemiplegia (paralysis on one side of body), osteoarthritis of knee, abnormalities of gait and mobility, lack of coordination, and pain. Resident 17's practitioner's medication orders included an order for Resident 17 to receive clopidogrel (Plavix; an anticoagulant medication that may cause bleeding and/or bruising) 75 mg (milligram) tablet daily by mouth. Resident 17's individual service plan (ISP) dated 10/11/2022 included Resident 17's and Former House Manager A's signatures. Resident 17's ISP included, "[Resident 17] is a moderate fall risk. Interventions is place." Resident 17's ISP included, "[Facility] will maintain standard fall precautions for each resident" including "ensuring resident has well-fitting foot wear (discouraging	{N 425}		

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flip-flops/no back slippers)" and "providing initial adaptive devices.." Resident 17's ISP included a list of adaptive equipment including "wheelchair, walker, cane." Resident 17's ISP included, "Give total assistance to resident with bathing/showering. Assist with dressing and undressing, wash, shampoo and with all required physical assistance."
Resident 17's ISP included, "[Caregivers] assist with transfers, while [Resident 17] uses walker for support."
Resident 17's ISP addressed Resident 17's ability to make his/her own needs known to caregivers.
Resident 17's "Fall Report" dated 06/16/2023 at 12:34 P.M. included, "Staff were trying to transfer resident onto the shower chair for shower." The report included, "Does the resident use assistive devices? Yes, wheelchair." The report included, "Was there anything on the floor that may have caused the resident to trip or fall? No." The report included, "Was the resident's wheelchair locked? N/A [not applicable]." The report included, "Was the resident using a cane/walker? No." The report included, "Was the resident wearing proper footwear? No."
Resident 17's caregiver observation documentation dated 06/16/2023 at 12:30 P.M. included, "[Resident 17] was transported to ER [emergency room] and found to have both ankles broken. [Resident 17] will be transferred to rehab [rehabilitation] after hospital discharge before returning to facility."

On 07/24/2023 at 11:48 A.M., Surveyor conducted an interview with Resident 17's Funding Agency Registered Nurse (RN) Z. Funding Agency RN Z told Surveyor Resident 17's funding agency was not informed by the facility of Resident 17's fall incident that occurred on 06/16/2023. Funding Agency RN Z said

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{N 425}	Continued From page 81 Resident 17's funding agency was unaware of Resident 17's incident, injuries, and hospitalization on 06/16/2023 until a call was received from a social worker at Resident 17's local hospital on 06/21/2023 to discuss Resident 17's hospital discharge planning. Resident 17's Funding Agency RN Z said Resident 17 had left-sided paralysis as the result of a previous stroke and required the use of a walker and assistance from one or two caregivers for all transfers at the facility. Resident 17's Funding Agency RN Z said prior to 06/16/2023 the funding agency was in the process of acquiring an electric wheelchair to replace Resident 17's standard wheelchair because Resident 17 was becoming too weak to propel the standard wheelchair independently. Resident 17's Funding Agency RN Z said Resident 17 experienced a left ankle fracture as a result of the fall incident on 06/16/2023 and now required the use of a Hoyer mechanical lift for all transfers. On 07/24/2023 at 2:05 P.M., Surveyor conducted an interview with Resident 17 and Resident 17's Funding Agency Case Manager SS. Resident 17 told Surveyor s/he was in his/her bedroom at the facility on 06/16/2023 when Agency Caregiver PP entered his/her room and told Resident 17 it was his/her first day at the facility and s/he did not know what s/he was doing. Resident 17 said s/he told Agency Caregiver PP s/he needed a shower. Resident 17 told Surveyor Agency Caregiver PP wheeled Resident 17 into his/her bathroom while Resident 17 was seated in his/her standard wheelchair. Resident 17 said Agency Caregiver PP tried to transfer him/her from the wheelchair to a shower chair located in Resident 17's shower. Resident 17 said Agency Caregiver PP did not utilize a walker nor a gait belt during the transfer. Resident 17 said Agency Caregiver	{N 425}		

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PP lifted him/her under his/her left, paralyzed arm. Resident 17 said s/he told Agency Caregiver PP his/her foot was caught on the bathroom floor mat when s/he started the transfer and Agency Caregiver PP continued with the transfer. Resident 17 said s/he told Agency Caregiver PP a second time about his/her foot being caught on the floor mat when Agency Caregiver PP bent down to move the mat and let go of Resident 17's left arm. Resident 17 told Surveyor s/he did not have enough strength to support his/her own body when Agency Caregiver PP let go of Resident 17's arm and Resident 17 fell to the floor before s/he reached the shower chair. Resident 17 said s/he heard something crack and it was his/her bones. Resident 17 told Surveyor, "You better believe I was in pain. I started crying, I was in so much pain." At this point during the interview, Resident 17 began to cry and Surveyor gave Resident 17 time to calm himself/herself. Resident 17 continued the interview with Surveyor by saying the wheelchair brakes were not locked during this transfer and the wheelchair moved when s/he began to fall. Resident 17 said s/he was not wearing any footwear during the transfer and s/he did not recall Agency Caregiver PP falling with Resident 17 to the floor. Resident 17 told Surveyor s/he did not understand why the facility would allow a caregiver that did not know Resident 17 to transfer Resident 17 in that manner. Resident 17 told Surveyor House Manager FF and House Manager EE showed up in Resident 17's room following the fall incident and called 911. Resident 17 said s/he was told by the facility caregivers Resident 17's fall incident was a "freak accident" and Resident 17 told Surveyor "it was not a freak accident." Resident 17 told Surveyor s/he was sent to a local emergency room, hospitalized, and then discharged to a local

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{N 425}	Continued From page 83 skilled nursing facility for rehabilitation. Resident 17 told Surveyor s/he now required the use of a Hoyer mechanical lift for all transfers. On 07/27/2023 2:04 P.M., Surveyor received Resident 17's hospital medical record documentation from the local hospital. The documentation included Resident 17 was admitted to the emergency room department on 06/16/2023 at 11:14 A.M. and "[Local fire department transport] from [facility] for assisted fall in the shower with staff. Tripped over the shower mat. Reports 1-2 assist normally. C/O [complaint of] pain to left lower leg/ankle area. On Plavix [medication]. Left side is paralized (sic)." The documentation included, "[Resident 17] now has severe pain in left knee and left ankle." Resident 17's emergency room diagnoses included, "Ankle fracture." The documentation dated 06/16/2023 at 2:41 P.M. included, "Work-up in the ED [emergency department] revealed no other medical problems. [A physician] advised splinting and non-weight bearing. An attempt was made to send [Resident 17] back to [his/her] assisted living facility, however [the assisted living facility] refused stating that [s/he] would need to go to rehab and [the assisted living facility] cannot provide the level of care [s/he] needs." Resident 17 was admitted to the local hospital. The documented hospital course included, "Left ankle fracture. Seen by Ortho [orthopedic practitioner] recommended non-surgical management of left ankle with splint and non-weight bearing for 6 weeks. [Resident 17] was discharged to subacute rehab in stable clinical condition." Resident 17 was discharged from the hospital on 06/26/2023.	{N 425}		

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{N 425}	Continued From page 84 On 08/03/2023 at 2:12 P.M., Surveyor conducted an interview with Administrator DD and discussed Resident 17's incident with significant injury on 06/16/2023. Administrator DD told Surveyor Resident 17 had not physically returned to the facility as of 08/03/2023, but had not been officially discharged from the facility. Example 2: Resident 4's post-surgical right posterior thigh wound On 07/19/2023 from 9:24 A.M., Surveyor observed as Caregiver II conducted morning medication administration related to Resident 4. Following administration of dispensed oral medications to Resident 4 as observed by Surveyor at 9:30 A.M., Caregiver II returned to the cart. Surveyor observed Caregiver II search the medication cart until 9:45 A.M. when Caregiver II asked House Manager EE where Resident 4's wound care supplies were located in the cart. Surveyor observed House Manager EE review Resident 4's electronic MAR and tell Caregiver II Resident 4's home health care services were recently at the facility and s/he would have to check Resident 4's wound care orders. On 07/19/2023, at approximately 9:45 a.m., Surveyor interviewed Resident 4. Resident 4 reported s/he had an area of skin cancer on his/her leg which got removed recently but could not recall when this occurred. At approximately 10:15 a.m., Surveyor observed House Manager EE inspecting Resident 4's right posterior thigh wound in his/her bathroom. House Manager EE removed the bandage covering the wound and visually inspected the skin underneath. House Manager EE reported that	{N 425}		

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{N 425}	Continued From page 85 Resident 4 had an appointment with his/her doctor the next day. House Manager EE clarified to Surveyor that this appointment was with his/her cancer doctor. On 07/19/2023, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 02/16/2021 with diagnoses including spastic hemiplegia, other paralytic syndrome, and unspecified urinary incontinence. Resident 4 was documented as being under guardianship. Surveyor reviewed Resident 4's ISP, last signed as reviewed on 10/19/2022, which documented under the "Lesion care" section, "Every 2 to 3 days bandage needs to be remove[sic] and replaced on right lower leg behind the knee. Date, Time, and initials, back of bandage. Plurogel to be applied directly on lesion using gloves & document it in observations." Within Resident 4's medical provider notes, Surveyor observed medical provider orders for different wound care components, including: saline wound wash 0.9% solution, gauze 4x4" bandages, Medipore soft cloth adhesive 4x10" tape, Curity abdominal 5x9" bandages, and skin prep towelettes. All had a start date of 05/19/2023. All indicated they were for wet-to-dry dressings, and the gauze bandages specifically indicated use for Resident 4's right posterior thigh. Surveyor reviewed Resident 4's medication administration record (MAR) from 06/01/2023 - 07/19/2023, where staff appeared to document Resident 4's right posterior thigh dressing changes. The above wound care components were documented as separate entries in the MAR. The abdominal pads, gauze pads, and skin prep wipes documented directions of "Wet to dry	{N 425}		

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{N 425}	Continued From page 86	{N 425}		

dressing as directed to right posterior thigh." The tape and wound wash documented directions of "Wet to dry dressing as directed."

Within the MAR, staff initialed off on completing dressing changes on 8 out of 16 total applicable dressing change days, which were set as being every 3 days. An annotation of "Medication pending delivery" was documented for the 6 dressing change days from 06/07/2023 - 06/25/2023 and 1 dressing day change on 07/01/2023.

Surveyor then observed Resident 4's observation notes from 06/01/2023 - 07/19/2023 and observed that staff documented changing Resident 4's dressing on 06/02/2023, 06/08/2023, 06/09/2023, 06/29/2023, and 07/13/2023.

Between Resident 4's MAR and observation notes from 06/01/2023 through 07/18/2023, as documented above, Surveyor observed that 1 dressing change was completed late (06/08/2023 instead of 06/07/2023). Surveyor also observed that for approximately 7 days dressing changes were warranted between 06/11/2023 - 07/02/2023, based on the below information, there was no evidence that they were completed:

- 06/01/2023: MAR entry for dressing change was blank

- 06/02/2023: Dressing was changed (per observation note entry)

- 06/04/2023: Dressing was changed (per MAR)

- 06/07/2023 (when the next dressing change would have been due according to the order): Wound care supplies marked as pending delivery

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{N 425}	Continued From page 87 in the MAR, no correlating observation note - 06/08/2023: Dressing changed (per observation note entry), 4 days after last change - 06/09/2023: Dressing changed (per observation note entry) - 06/12/2023 (when the next dressing change would have been due according to the order): No MAR or observation note entry. MAR entries for 06/10/2023 and 06/13/2023 indicated that wound care supplies were pending delivery. - 06/15/2023 (when the next dressing change would have been due according to the order): No MAR or observation note entry. MAR entries for 06/13/2023 and 06/19/2023 indicated that wound care supplies were pending delivery. A MAR entry for a dressing change on 06/15/2023 was blank. - 06/18/2023: (when the next dressing change would have been due according to the order): No MAR or observation note entry. MAR entries for 06/13/2023 and 06/19/2023 indicated that wound care supplies were pending delivery. A MAR entry for a dressing change on 06/15/2023 was blank. - 06/21/2023: (when the next dressing change would have been due according to the order): No MAR or observation note entry. MAR entries for 06/19/2023 and 06/22/2023 indicated that wound care supplies were pending delivery. - 06/24/2023: (when the next dressing change would have been due according to the order): No MAR or observation note entry. MAR entries for 06/22/2023 and 06/25/2023 indicated that wound care supplies were pending delivery.	{N 425}		

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{N 425}	Continued From page 88 - 06/27/2023: (when the next dressing change would have been due according to the order): No MAR or observation note entry. - 06/28/2023: Dressing was changed (per MAR entry) - 06/29/2023: Dressing was changed (per observation note entry) - 07/02/2023: (when the next dressing change would have been due according to the order): A MAR entry for 07/01/2023 indicated that wound care supplies were pending delivery. On 07/19/2023, at approximately 4:30 p.m., Surveyor interviewed Resident 4 again. When asked if s/he had his/her thigh bandage changed that day yet, Resident 4 replied s/he wasn't sure. Resident 4 reported remembering that House Manager EE had inspected the bandage earlier that day with Surveyor present. Upon reviewing the MAR again on 07/19/2023, Surveyor observed that Caregiver II initialed off on completing Resident 4's dressing change at 11:25 a.m. that morning, however, based on earlier observations by Surveyor, Caregiver II was not observed to have completed Resident 4's dressing change. On 07/19/2023, at approximately 4:45 p.m., Surveyor interviewed House Manager EE. House Manager EE confirmed that staff are supposed to change Resident 4's thigh dressings. When asked about the instances in which staff documented Resident 4's dressing changes were pending delivery throughout the last half of June, House Manager EE replied s/he knew at one point that Resident 4 had been running out of	{N 425}		

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{N 425}	Continued From page 89 his/her wound care supplies. When Surveyor discussed the concern that Caregiver II was not observed to have completed Resident 4's dressing change (which would have been due) and especially at the time s/he documented completing it, House Manager EE replied that s/he was sure Caregiver II didn't change it. House Manager EE reported s/he already discussed his/her concerns about Caregiver II administering medications and treatments with Administrator DD. Summary: The provider did not ensure Resident 17 and Resident 4 were provided with personal care services adequate to meet their individual needs. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0205 DHS 83.14(2)(i) Not Permit A Condition Of Substantial Risk	{N 425}		
{N 431}	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N	{N 431}		

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{N 431}	Continued From page 90 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure adequate health monitoring was provided to meet the needs of Resident 4, Resident 19, and Resident 12. Between 06/01/2023 - 07/19/2023, there was no evidence that Resident 4's blood pressure was monitored on 10 days despite having medical provider-ordered notification parameters. On 07/18/2023, there was no evidence that Resident 4's medical provider was notified when his/her recorded blood pressure was within notification parameters. Between 06/02/2023 - 07/13/2023 (when Resident 4's home health nursing was initiated), it was unclear how staff were monitoring and addressing Resident 4's coccyx wound despite Resident 4 having known baseline	{N 431}		

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{N 431}	Continued From page 91 skin issues as identified in his/her individual service plan (ISP) and coccyx/buttocks skin concerns documented by staff on 06/02/2023, 06/12/2023, and 06/18/2023. Resident 19's blood pressure was not monitored and documented within Resident 19's record daily from 06/01/2023 through 07/19/2023, with the exception of two occurrences. Resident 19's practitioner's orders included an order to call Resident 19's physician if Resident 19's systolic blood pressure was less than 90 associated with two blood pressure medications to be administered to Resident 19 on a daily basis. Resident 12's pulse was not monitored and documented within Resident 12's record daily from 07/02/2023 through 07/19/2023. Resident 12's practitioner's orders included an order to call Resident 12's physician if Resident 12's pulse was less than 55, or greater than 120 beats per minute associated with Resident 12's prescription of metroprolol (blood pressure and heart failure medication). This requirement is being cited for the second time. See SOD 705414, issued on 04/14/2023. The findings include: On 07/19/2023, with information gathered through 08/03/2023, Surveyors conducted a complaint investigation and verification visit regarding concerns with medication administration and health monitoring. Example 1: Resident 4's blood pressure and coccyx wound monitoring On 07/19/2023, at approximately 9:45 a.m.,	{N 431}		

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Surveyor interviewed Resident 4. Resident 4 reported s/he had a tailbone wound that was managed by staff. Resident 4 reported that this wound had been present since even before his/her admission to the provider and s/he wasn't sure if it was currently open or not.

On 07/19/2023, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 02/16/2021 with diagnoses including hypertension and sacral pressure ulcer. Resident 4 was prescribed Lisinopril 5 mg tablet with the following instructions: "Take 1 tablet by mouth daily for hypertension. Update [medical doctor] if systolic [blood pressure] less than 110 or greater than 180, diastolic less than 55 or greater than 100 and pulse less than 55, or greater than 120 [beats per minute]."

Surveyor reviewed Resident 4's medication administration record (MAR) from 06/01/2023 - 07/19/2023, where staff appeared to record Resident 4's daily blood pressure readings, and observed the following 10 days where staff did not record a blood pressure for Resident 4:

- 06/11/2023
- 06/16/2023
- 07/06/2023
- 07/07/2023
- 07/09/2023
- 07/10/2023
- 07/11/2023
- 07/12/2023
- 07/13/2023
- 07/16/2023

Surveyor also observed that on 07/18/2023, Resident 4's blood pressure was documented as 138/51 (diastolic blood pressure reading within

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medical provider notification parameters). In reviewing Resident 4's record, including his/her MAR and observation notes for that day, Surveyor did not observe any evidence that Resident 4's medical provider was notified of this blood pressure reading.

Within the MAR, there was also an as-needed (PRN) entry for wound care with instructions to "Cleanse coccyx wound with wound cleanser, pat dry, cover with Meplix" for every 3 days as needed. From 06/01/2023 - 07/19/2023 there were no annotations indicating wound care was completed for Resident 4's coccyx wound.

Surveyor reviewed Resident 4's ISP, last signed as reviewed on 10/19/2022, documented the following in relation to Resident 4's skin:

- Under the "Recurring illnesses" section: " ...has occasional episodes of skin issues ...Document observations and report to manager any changes in condition ..."
- Under the "Sleep patterns" section: " ...[S/he] does obtain pressure spots that have the potential to break down due to [his/her] choice to sleep in chair ..."

Surveyor then reviewed Resident 4's observation notes from 06/01/2023 - 07/19/2023, and observed the following:

- 06/02/2023: " ...while toileting resident staff noticed resident has scabbed areas an[sic] area red in tail bone area." An additional entry that day documented, ""I was notified of redness and scabbing on resident's bottom. I contacted [Resident 4's physician] to notify of problem. [Resident 4's physician] will be reaching out regarding the redness and scabbing on bottom.

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{N 431}	Continued From page 94 Will update once contacted back." - 06/12/2023: "The writer observed the residents[sic] bottom was red in color and has what looks like scratches on [his/her] upper buttocks. The writer also observed a small sore that is about the size of a dime and is yellow in color. The writer observed the sore to look like it was scabbed over. The writer informed the house manager. The writer also looked for barrier cream and none was found. The writer will continue to observe and monitor this." - 06/18/2023: " ...resident called a few times in the night and was complaining of having sores on bottom that hurt." - 07/13/2023: " ...[Registered nurse] from [home health company] came to evaluation[sic] catheter and wound on inner thigh area." There was no other information in Resident 4's record about his/her wound/coccyx area monitoring completed by staff. On 07/19/2023, at approximately 4:45 p.m., Surveyor interviewed House Manager EE. House Manager EE acknowledged Surveyor's concern that staff did not seem to be consistently monitoring Resident 4's blood pressure as directed by his/her medical provider. House Manager EE confirmed s/he had no evidence that Resident 4's medical provider was notified on 07/18/2023 when his/her blood pressure was within notification parameters and reported s/he did not know if staff notified his/her medical provider. When asked about Resident 4's coccyx wound monitoring, House Manager EE reported s/he noticed a lack of documentation regarding Resident 4's wound since s/he had been helping	{N 431}		

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{N 431}	Continued From page 95 to fill in for managing the facility. House Manager EE reported that the provider's nurses had been conducting wound care before, but since the last nurse left approximately 1 month ago, Resident 4's coccyx wound was being managed by caregiving staff. House Manager EE reported that s/he initiated home health for Resident 4 to manage the care of his/her coccyx wound and showed Surveyor a communication note from Resident 4's home health nurse. In reviewing the note, Surveyor observed that the note indicated a home health evaluation was completed on 07/13/2023 for catheter management and coccyx/buttocks wounds with the next follow-up visit anticipated to be around 08/07/2023 (in the future). House Manager EE acknowledged Surveyor's concern that it was unclear what staff were doing to monitor Resident 4's wound, especially between 06/02/2023 (when staff first observed a change) and 07/13/2023 (date of home health evaluation) and how they were addressing it due to the lack of documentation. Example 2 : Resident 19's blood pressure monitoring and parameters associated with medication administration On 07/19/2023 at 8:45 A.M., Surveyor observed as Caregiver II conducted morning medication administration related to Resident 19. Surveyor observed Caregiver II dispense several different oral medications into a medication cup for Resident 19, including 1 amlodipine [Norvasc; high blood pressure medication] 10 mg [millgram] tablet and 1 hydrochlorothiazide [high blood pressure medication] 25 mg tablet before Caregiver II administered the medications to Resident 19 in the dining room. Surveyor did not observe Caregiver II monitor Resident 19's blood	{N 431}		

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pressure before or following administration of these medications. Caregiver II told Surveyor s/he did not take Resident 19's blood pressure and was not aware of having to take Resident 19's blood pressure prior to medication administration.

On 07/19/2023, Surveyor reviewed Resident 19's demographic data, practitioner's orders, blood pressure documentation from 06/01/2023 through 07/19/2023, and Resident 19's July 2023 MAR (medication administration record), as received by House Manager EE. Resident 19 was admitted to the facility on 03/05/2020 and had diagnoses including "mental handicap" and hypertension (high blood pressure). Resident 19's practitioner's orders include an order for amlodipine 10 mg and hydrochlorothiazide 25 mg to be administered to Resident 19 daily for high blood pressure. Both practitioner's orders include "Call MD [medical doctor] if SBP [systolic blood pressure] is less than 90." Resident 19's blood pressure documentation from 06/01/2023 through 07/19/2023 included two dates in which Resident 19's blood pressure was monitored and documented within Resident 19's record, on 06/07/2023 and 06/14/2023. Resident 19's July 2023 MAR included daily documentation of administration of amlopidine and hydrochlorothiazide to Resident 19, as ordered.

On 08/03/2023at 2:12 P.M., Surveyor conducted an interview with Administrator DD. Administrator DD told Surveyor s/he reviewed Resident 19's electronic MAR and a directive for caregivers to check Resident 19's vital signs, including blood pressure, "pops up" on the MAR associated with Resident 19's medication administration.

Example 3: Resident 12's pulse monitoring and

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{N 431}	Continued From page 97 parameters associated with medication administration On 07/19/2023 from 8:59 A.M. until approximately 9:23 A.M., Surveyor observed as Caregiver II conducted morning medication administration related to Resident 12. Surveyor observed Caregiver II dispense several different oral medications into a medication cup for Resident 12, including metroprolol (blood pressure and heart failure medication) 12.5 mg. At 9:10 A.M., Surveyor observed Caregiver II administer Resident 12's oral medications to Resident 12 seated in a wheelchair located in Resident 12's bedroom. Surveyor observed Caregiver II did not monitor any vital signs for Resident 12 prior to medication administration. At 9:18 A.M., Surveyor observed Caregiver II return to Resident 12's room with an automatic blood pressure cuff. Surveyor observed Caregiver II apply the blood pressure cuff below (distal to) Resident 12's left elbow. Surveyor observed a diagram including instruction for correct application of the cuff to be placed just above (proximal to) the elbow. Surveyor asked Caregiver II if s/he was sure s/he had properly placed the cuff based on the diagram. Caregiver II told Surveyor s/he placed the cuff below the elbow sometimes and sometimes above it. Caregiver II stated, "I [Caregiver II] don't really pay attention. It has been awhile since someone showed me [Caregiver II] how to take a blood pressure." Surveyor observed Caregiver II continue taking Resident 12's blood pressure and pulse with the cuff located below the elbow until a reading could not be established. Surveyor asked Caregiver II about proper placement of the cuff a second time. Surveyor observed Caregiver II place the cuff based on the diagram instructions and Resident 12's blood pressure	{N 431}		

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(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 431}	Continued From page 98	{N 431}		

and pulse were established. At 9:23 A.M., Caregiver II returned to the medication cart and documented Resident 12's pulse and administration of Resident 12's metroprolol, even though Resident 12's metroprolol was administered at 9:10 A.M. prior to Resident 12's pulse being monitored.
Surveyor reviewed Resident 12's demographic data, practitioner's orders, July 2023 MAR, and Resident 12's vital sign documentation from 07/01/2023 through 07/19/2023, as received by House Manager EE. Resident 12 was admitted to the facility on 09/16/2013 and had diagnoses including mitral and aortic valve [heart] insufficiency and hypertension. Resident 12's practitioners' orders and July 2023 MAR included a prescription for metroprolol 12.5 mg to be administered for elevated heart rate and "Update MD [medical doctor] if pulse is less than 55, or greater than 120 BPM [beats per minute]."
Surveyor compared Resident 12's July 2023 MAR and Resident 12's vital sign documentation from 07/01/2023 and 07/19/2023. Based on Resident 12's July 2023 MAR, Resident 12 was hospitalized on 07/01/2023 and was not administered prescribed medications at the facility. Between 07/02/2023 and 07/19/2023, Resident 12's MAR included daily administration documentation of metroprolol, with the exception of 07/08/2023 in which no prescribed, scheduled morning medications were documented as administered by the caregivers. Between 07/02/2023 and 07/19/2023, Resident 12's pulse was not monitored, as ordered, on 07/05/2023, 07/07/2023, 07/08/2023, 07/10/2023, 07/11/2023, 07/12/2023, and 07/16/2023. As observed on 07/19/2023 at 9:10 A.M., Resident 12's metroprolol was administered before Resident 12's pulse was monitored by Caregiver II.

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{N 431}	Continued From page 99 On 08/03/2023at 2:12 P.M., Surveyor conducted an interview with Administrator DD. Administrator DD told Surveyor any practitioner's orders including parameters should be followed as written. When the caregivers take a blood pressure, pulse, or any reading, the caregivers should document the reading within the resident's record and contact the practitioner if the reading is outside of the parameters, as ordered. Summary: The provider did not ensure adequate health monitoring was provided to meet the needs of Resident 4, Resident 19, and Resident 12. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0205 DHS 83.14(2)(i) Not Permit A Condition Of Substantial Risk N0441 DHS 83.39(3) Hand Washing	{N 431}		
{N 441}	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure Caregiver II followed appropriate hand washing procedures, as required. On 07/19/2023, Surveyor observed Caregiver II conduct approximately 3 hours of morning medication pass without performing appropriate hand washing procedures.	{N 441}		

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{N 441}	Continued From page 100 This requirement is being cited for the second time. See SOD 705414, issued on 04/14/2023. The findings include: On 07/19/2023, Surveyors conducted verification visit including concerns with hand washing procedures. On 07/19/2023 between approximately 07:40 A.M. and approximately 10:35 A.M., Surveyor observed as Caregiver II conducted a portion of the morning medication pass for approximately 3.5 hours without changing his/her gloves or washing his/her hands. Surveyor observed Caregiver II touch residents, objects on the medication cart, including the facility's shared laptop to review and document resident medication administration records (MARs), dispense and administer resident medications, touch a blood pressure cuff shared between residents, and touch medication administration supplies, including medication bubble packs, insulin pens, eye medications, and blood glucose monitors. On 07/19/2023 between 7:40 A.M. until approximately 8:26 A.M., Surveyor observed as Caregiver II conducted morning medication administration related to Resident 3. Surveyor observed Caregiver II had a pair of gloves donned, one on each hand. Surveyor observed Caregiver II monitor Resident 3's blood glucose, monitor Resident 3's blood pressure, and dispense and administer oral medications while Resident 3 was seated at a table located in the facility's dining room. Surveyor observed Caregiver II did not remove his/her gloves and perform hand washing	{N 441}		

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{N 441}	Continued From page 101 procedures at any time during Resident 3's medication pass observations nor between Resident 3's and Resident 14's medication pass observations. On 07/19/2023 at 8:27 A.M., Surveyor observed Resident 14 approach the medication cart in his/her wheelchair. Surveyor observed Resident 14 ask Caregiver II if s/he could be administered his/her inhalers. Surveyor observed Caregiver II dispense and hand a Symbicort inhaler [inhaled respiratory medication] to Resident 14, and Surveyor observed Resident 14 administer 1 inhalation of Symbicort to self before handing it back to Caregiver II. Surveyor observed Caregiver II did not remove his/her gloves and perform hand washing procedures at any time during Resident 14's medication pass observations nor between Resident 14's and Resident 11's medication pass observations. On 07/19/2023 at 8:34 A.M., Surveyor observed as Caregiver II conducted morning medication administration related to Resident 11. Surveyor observed Caregiver II dispense medications prescribed for Resident 11. Surveyor observed Caregiver II find a small, white, loose tablet at the bottom of the medication drawer and place it within the medication cup containing other medications dispensed for Resident 11 before removing the tablet from the cup and placing it in a separate medication cup. Caregiver II gave that separate medication cup to House Manager GG and told him/her s/he found the tablet at the bottom of the cart and it needed to be destroyed. Surveyor observed Caregiver II administer the dispensed medications to Resident 11.	{N 441}		

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{N 441}	Continued From page 102 Surveyor observed Caregiver II did not remove his/her gloves and perform hand washing procedures at any time during Resident 11's medication pass observations nor between Resident 14's and Resident 11's medication pass observations. On 07/19/2023 at 8:45 A.M., Surveyor observed as Caregiver II conducted morning medication administration related to Resident 19, who is blind in his/her right eye. Surveyor observed Caregiver II dispense several different oral medications into a medication cup for Resident 19. Surveyor observed Caregiver II approach Resident 19 from Resident 19's right side as Resident 19 was seated at a dining room table. Surveyor observed all of the medications from the medication cup spill on to the table as Caregiver II handed the medications to Resident 19. Resident 6, seated across from Resident 19 at the table, assisted Resident 19 locate two medications caught under Resident 19's left arm that Caregiver II did not notice as s/he picked up the other medications from the table. At 8:53 A.M., while Caregiver II was removing Resident 19's eye medication from the medication cart Surveyor observed Caregiver II ask Resident 19 to return to his/her bedroom so Caregiver II could administer Resident 19's eye medication. Once in Resident 19's bedroom, Surveyor observed Caregiver II administer a thin ribbon of Soothe Night eye ointment to Resident 19's right eye, as prescribed, which required Caregiver II to tough Resident 19's face and tube of ointment. Surveyor observed Caregiver II did not remove his/her gloves and perform hand washing procedures at any time during Resident 19's medication pass observations nor between	{N 441}		

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{N 441}	Continued From page 103 Resident 19's and Resident 13's medication pass observations. On 07/19/2023 at 8:54 A.M., Surveyor observed as Caregiver II conducted morning medication administration related to Resident 13. Surveyor observed Caregiver II dispense and administer several oral medications to Resident 13. Surveyor observed Caregiver II did not remove his/her gloves and perform hand washing procedures at any time during Resident 13's medication pass observations nor between Resident 13's and Resident 12's medication pass observations. On 07/19/2023 from 8:59 A.M. until approximately 9:23 A.M., Surveyor observed as Caregiver II conducted morning medication administration related to Resident 12. Surveyor observed Caregiver II dispense several different oral medications into a medication cup for Resident 12. Surveyor observed Caregiver II remove Resident 12's Nyamyc antifungal, topical powder container from the medication cart. At 9:10 A.M., Surveyor observed Caregiver II administer Resident 12's oral medications to Resident 12 seated in a wheelchair located in Resident 12's bedroom. Surveyor observed Caregiver II did not administer Resident 12's topical medication before returning the container to the medication cart. At 9:18 A.M., Surveyor observed Caregiver II return to Resident 12's room with an automatic blood pressure cuff and take Resident 12's blood pressure and pulse readings. At 9:23 A.M., Caregiver II returned to the medication cart and documented Resident 12's pulse. Surveyor observed Caregiver II did not remove	{N 441}		

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{N 441}	Continued From page 104	{N 441}		

his/her gloves and perform hand washing procedures at any time during Resident 12's medication pass observations nor between Resident 12's and Resident 4's medication pass observations.

On 07/19/2023 from 9:24 A.M., Surveyor observed as Caregiver II conducted morning medication administration related to Resident 4. Surveyor observed Caregiver II dispense several oral medications into the medication cup before returning the medication bubble packs to the medication cart. Following administration of the dispensed oral medications to Resident 4 seated outside as observed by Surveyor at 9:30 A.M., Caregiver II returned to the cart. Surveyor observed Caregiver II search the medication cart until 9:45 A.M. when Caregiver II asked House Manager EE where Resident 4's wound care supplies were located in the cart. Surveyor observed Caregiver II dispense Resident 4's lisinopril tablet into a medication cup and stand looking at the top of the medication cart holding the medication cup. Surveyor asked Caregiver II what s/he was doing. Caregiver II told Surveyor s/he was waiting for House Manager EE to return to the cart because s/he did not want to have to walk to Resident 4 twice. Surveyor observed House Manager EE tell Caregiver II not to wait for House Manager EE while s/he checked on Resident 4's wound care orders. At 9:48 A.M., Surveyor observed Caregiver II take Resident 4's blood pressure and administer Resident 4's lisinopril before returning to the cart to document administration of Resident 4's medications.

Surveyor observed Caregiver II did not remove his/her gloves and perform hand washing procedures at any time during Resident 4's medication pass observations nor between

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{N 441}	Continued From page 105 Resident 4's and Resident 5's medication pass observations. On 07/19/2023 at 9:50 A.M., Surveyor observed as Caregiver II conducted morning medication administration related to Resident 5. Surveyor observed Caregiver II dispense several different oral medications into a medication cup for Resident 5. Surveyor observed Caregiver II remove Resident 5's Nyamyc topical, antifungal powder from the top drawer of the medication cart and place it on top of the medication cart. Surveyor observed Caregiver II attempt locate Resident 5's glucometer and glucometer test strips for several minutes within the medication cart. Caregiver II took a test strip from Resident 3's container and attempted to insert it into Resident 5's glucometer without success and return the test strip to Resident 3's container. At 10:10 A.M., Surveyor observed Caregiver II return Resident 5's Nyamyc powder to the top drawer of the medication cart. At 10:14 A.M., Surveyor observed Caregiver II remove Resident 5's Humalog insulin (fast-acting insulin to control blood glucose) pen from the cart and approach Resident 5 seated in a recliner located in the facility's front living room area. Surveyor observed Caregiver II administer 3 units of Humalog insulin to Resident 5. Surveyor observed Caregiver II administer Resident 5's oral medications, as dispensed. Surveyor observed Caregiver II return to the medication cart and search the top drawer of the medication cart. At 10:21 A.M., Caregiver II told Surveyor s/he was unable to locate Resident 5's eye drops to be administered during the morning medication pass. At 10:25 A.M., Surveyor observed Caregiver II return to Resident 5 and take Resident 5's blood pressure and pulse. At 10:33	{N 441}		

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{N 441}	Continued From page 106 A.M., Surveyor observed Caregiver II return to the medication cart and prepare Resident 5's glucometer. At 10:35 A.M., Surveyor observed Caregiver II take Resident 5's blood glucose reading. Surveyor observed Caregiver II did not remove his/her gloves and perform hand washing procedures at any time during Resident 5's medication pass observations. On 07/19/2023 at 4:04 P.M., Surveyor conducted an interview with House Manager EE. House Manager EE told Surveyor s/he observed Caregiver II did not follow hand washing procedures during the morning medication pass. House Manager EE told Surveyor Caregiver II should have changed his/her gloves and washed or used hand sanitizer to both hands between each resident's medication administration. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0205 DHS 83.14(2)(i) Not Permit A Condition Of Risk N0352 DHS 83.32(3)(h) Resident Of Residents: Receive Medications	{N 441}		
{N 447}	83.41(1)(c) Dishwashing Dishwashing. 1. Whether washed by hand or mechanical means, all equipment and utensils shall be cleaned using separate steps for pre-washing, washing, rinsing and sanitizing. Residential dishwashers may be used in kitchens serving 20 or fewer residents. Kitchens serving 21 or more residents shall have a commercial type dishwasher for washing and sanitizing	{N 447}		

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equipment and utensils in accordance with standard practices described in the Wisconsin food code. 2. A 3-compartment sink for washing, rinsing and sanitizing utensils, with drain boards at each end is required for all large facilities with a central kitchen. Washing, rinsing and sanitizing procedures shall be in accordance with standard practices described in the Wisconsin food code. In addition, a single compartment sink or overhead spray wash located adjacent to the soiled drain board is required for pre-washing.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure that all equipment and utensils were cleaned using separate steps for pre-washing, washing, rinsing, and sanitizing.

This requirement is being cited for the third time. See Statement of Deficiency (SOD) 705414, issued 04/14/2023, and 705413, issued 12/01/2022.

The findings include:

On 07/19/2023, Surveyors conducted verification visit including concerns with dishwashing procedures.

On 07/19/2023, at approximately 8:30 a.m., Surveyor observed Caregiver JJ washing dishes at the kitchen sink. Caregiver JJ was observed pouring dish soap and bleach into the right sink compartment before filling it with water. Caregiver JJ was then observed putting dishes into the compartment where they were left to soak for several minutes. Caregiver JJ was then observed washing dishes in the bleach/soap mix and then

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{N 447}	Continued From page 108 stacking dishes to dry in the left sink compartment. Surveyor did not observe the sanitizing of dishes as its own step in the dishwashing process. On 07/27/2023, at approximately 8:00 a.m., Surveyor interviewed Administrator DD. Administrator DD reported that after Surveyors were on site s/he had Administrative Assistant HH put up dishwashing instructions in the kitchen with the step-by-step process for caregivers to follow. Administrator DD reported frustration that dishwashing continued to be an issue but reported that s/he observed caregivers washing dishes following the correct procedure during previous times s/he had been on site. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	{N 447}		
{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 interview, the provider did not ensure that the living environment was safe, clean, comfortable, and homelike. This requirement is being cited for a third time. See SOD 705414, issued on 04/14/2023, and	{N 481}		

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{N 481}	Continued From page 109 SOD 705413, issued 12/01/2022.. Findings include: On 07/19/2023, Surveyors conducted verification visit including concerns with the facility's environment. On 07/19/2023, Surveyor toured the environment and observed the following: - At approximately 7:39 a.m., Surveyor observed the living room windows. All windowsills and ledges near the chairs and television contained small bits of debris and several dead insects (see Photos 1-4). - At approximately 7:46 a.m., an air vent in the south wing was observed covered in dust (see Photo 5). - From approximately 8:00 - 8:13 a.m., Surveyor observed the back patio door fully open (see Photo 6). At approximately 8:13 a.m., Surveyor observed Caregiver JJ push Resident 4 in his/her wheelchair through the hallway and open patio door to the patio outside. Upon re-entering the facility, Caregiver JJ walked through the open door and back to a different area of the facility without closing the door. Surveyor observed the patio door again at 8:28 a.m. which was no longer fully open but was still open approximately 3 inches (see Photo 7). Throughout the afternoon, several flies were observed in the facility, landing on the activity table and flying around Surveyors. - At approximately 9:18 a.m., Surveyor observed a pile of laundry sitting loosely on the floor of the laundry room (see Photo 8). There was no indication as to who the laundry belonged to and	{N 481}		

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{N 481}	Continued From page 110 whether the laundry was soiled or clean. - From approximately 9:28 - 10:19 a.m., Surveyor toured the room of Residents 4 and 5. The carpet in front of and to the left of the Resident 4's recliner was stained in approximate 1x2' areas (see Photo 9). Three holes in the wall were observed in the area between Resident 4's window and behind his/her recliner (see Photo 10). The left hole, underneath the right curtain, measured approximately 2x3 inches. The middle hole, under and to the right of the right curtain, measured approximately 1.5x8 inches. The right hole, on the other wall behind Resident 4's recliner, appeared open and extending through the drywall and was approximately the size of Surveyor's hand (see Photo 11). During this observation, Surveyor asked Resident 4 how long the holes had been in his/her wall. Resident 4 replied that they had been there since his/her admission a couple of years ago. In the bathroom, a dark stain was observed extending approximately 3 feet total across the wall near the air register (see Photo 12). This area also appeared to have chipped and peeling paint. The toilet bolt cover was missing, exposing the bolt and rust surrounding the bolt (see Photo 13). The doorknob of the bathroom door appeared to be hanging loosely in the doorknob opening (see Photo 14). The doorlatch was missing from the doorknob assembly (see Photo 15). - At approximately 10:28 a.m., Surveyor interviewed Resident 14. Resident 14 reported that there was a camera in the dining room, put up by Former House Manager M a few months ago. Resident 14 reported that s/he felt s/he was being spied on by Former House Manager M and expressed concern that Administrator DD was watching residents through the camera. Resident	{N 481}		

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(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 481}	Continued From page 111 14 reported feeling upset by the camera's presence and that s/he felt staff used it to monitor residents. Surveyor then went out to the dining area and observed a camera partially hidden installed into one of the dining room light fixtures (see Photos 16 and 17). The camera appeared to face a walkway in the dining area near the laundry room. There was no sign indicating that recording was taking place. At approximately 4:45 p.m., Surveyor interviewed House Manager EE. House Manager EE reported that Former House Manager M had put up the camera but wasn't sure why. House Manager EE reported s/he thought that Former House Manager M was able to monitor the camera's feed. House Manager EE reported s/he was unable to access the camera's feed and didn't know of any current staff that had access. House Manager EE acknowledged Surveyor's concern that there was no way to confirm whether Former House Manager M was still able to view the camera's feed despite no longer being employed by the provider. House Manager EE stated, "I think I'm just going to take it down" and was observed by Surveyor taking the camera out of the dining light fixture. On 07/27/2023, at approximately 8:00 a.m., Surveyor interviewed Administrator DD. Administrator DD reported after Surveyors were on site s/he had staff address the living room windows. In discussing the open patio door, Administrator DD reported s/he thought Caregiver JJ may have left the door open because some residents struggle to get the door open but acknowledged that this may not be the best solution. Administrator DD acknowledged that the pile of laundry observed by Surveyor sitting on the laundry room floor was a concern and reported that staff should not be having laundry sitting on the floor. Administrator DD acknowledged the	{N 481}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017749	A. BUILDING: _____ B. WING _____	R-C 08/03/2023

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{N 481}	Continued From page 112 concerns with the shared bedroom and bathroom for Residents 4 and 5 and reported that maintenance staff would address them. In discussing the dining room camera, Administrator DD reported s/he did not believe the camera was operational anymore and that the previous administrator changed the account information. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	{N 481}		