STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013151	A. BUILDING: _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOBOLINK HOME	**834 BOBOLINK LN WEST BEND, WI 53095**

(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
M 000	INITIAL COMMENTS On 07/30/2024, with information gathered through 08/01/2024, Surveyor conducted an abbreviated licensure survey and a complaint investigation at Bobolink Home. Six deficiencies were identified. Complaint was substantiated. Census: 4	M 000		
M 230	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider permitted an existence and continuation of a condition in the home which placed the health, safety, and welfare for 4 of 4 residents at substantial risk of harm. Home Coordinator B, who had been on required medical leave due to Covid, arrived at the home to assist the Surveyor. Provider allowed Resident 2 to sit next to Resident 1 on the transport van, which resulted in Resident 2 touching Resident 1 inappropriately. Findings include: Example 1: Covid On 07/30/2024 at 1:22 PM, Surveyor called	M 230		

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

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M 230	Continued From page 1 Administrator A via telephone to confirm access to the home to conduct an abbreviated licensure survey and a complaint investigation. Administrator A informed Surveyor that both of his/her managers were out due to Covid. Surveyor stated s/he would return to the home when the residents were in the home that afternoon. On 07/30/2024, at approximately 3:30 PM, Surveyor arrived at the home and was greeted by Home Coordinator B. Home Coordinator B was wearing a mask and confirmed s/he had been diagnosed with Covid. Surveyor observed residents and staff in the home who were not wearing masks. Home Coordinator B stated the residents had not been diagnosed with Covid. Home Coordinator B stated it was company policy that a manager be onsite when a surveyor is in the building. Throughout the survey process, 3:30 PM to 5:00 PM, Home Coordinator B assisted Surveyor. Surveyor noted Home Coordinator B appeared lethargic and congested. "HCP with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and At least 24 hours have passed since last fever without the use of fever-reducing medications, and Symptoms (e.g., cough, shortness of breath) have improved.	M 230		

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M 230	Continued From page 2	M 230		

HCP with severe to critical illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met:
At least 10 days and up to 20 days have passed since symptoms first appeared, and
At least 24 hours have passed since last fever without the use of fever-reducing medications, and
Symptoms (e.g., cough, shortness of breath) have improved." (Source: CDC (Centers for Disease Control and Prevention) Website, Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, March 18, 2024, Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | COVID-19 | CDC (retrieval date - 07/31/2024).)

Example 2: Resident 1

On 07/23/2024, the Department received a concern alleging a resident had touched another resident inappropriately.

On 07/30/2024, at approximately 4:00 PM, Surveyor interviewed Home Coordinator (HC) B. HC B stated s/he was aware that Resident 1 had reported that Resident 2, who resides at a sister facility, had touched him/her inappropriately during a transport to a day program. HC B stated when s/he was made aware of the concern by Resident 1's Guardian C, s/he immediately informed staff that Resident 2 is not allowed to sit next to Resident 1 and is to ride in the front seat of the transport van. Resident 2 is not to be unsupervised if a group activity is occurring between residents. HC B stated s/he did inform Guardian C that if s/he felt that law enforcement

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M 230	Continued From page 3	M 230		

should be contacted, s/he should follow through with that which s/he did.

On 07/31/2024, Surveyor requested Resident 1's police report from local law enforcement.

On 08/01/2024, Surveyor reviewed the police report which documented:
"06/22/2024 at 10:29 AM [Officer] met with and interviewed [Guardian C]. ... [Guardian C] said [Resident 1] was a person with cognitive and emotional issues. [Guardian C] said [Resident 1] was a high-functioning individual and was able to communicate verbally. ... [Guardian C] showed me the text message for me to read ... 'Guess what [mom/dad] [Resident 2] from the other house touch me in a appreciate [sic: inappropriate] this morning down on my leg by my private I am very sercrs [sic: serious] me [mom/dad] [s/he] is a very inappropriate [guy/gal] and [s/he] likes [wo/men] ... [Guardian C] said [Resident 1] told [him/her] [s/he] told one of the group home staff about what happened, and they said [Resident 2] was not supposed to have physical contact with any [fe/males]. [Guardian C] said [Resident 1] told [him/her] [s/he] told [his/her] housemates about the incident, and they told [Resident 1] [Resident 2] had touched [fe/males] inappropriately in the past prior to [Resident 1] moving into [his/her] current group home location in March, 2023. ..."
"06/22/2024 at 11:05 AM [Officer] met with and interviewed [Resident 1] ... [Resident 1] said on Thursday, 06/22/24, sometime between 8:30 and 9:00 AM, [s/he] had been transported by passenger van from the [provider home] to [day program]. [Resident 1] said [Resident 2] sat next to [him/her] in the transport van. [Resident 1] said at some point during the transport, [Resident 2] placed one of [his/her] hands on the inside of

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M 230	Continued From page 4 [his/her] left leg at [his/her] [private area]. ..." "06/22/2024 at 11:24 AM [Officer] contacted [HC B] by phone and discussed the complaint with [him/her], and [HC B] confirmed [s/he] was aware of the incident. ... [HC B] said [Resident 2] had a history of prior inappropriate contact with other [fe/male] resident years ago, and that was why [s/he] no longer resided at [Resident 1's provider home]. ... [HC B] said [Resident 2] currently resided with only [fe/male] clients ... [HC B] said [Resident 2] should not have been allowed to sit with [Resident 1] during the transport, and [s/he] said steps had been taken with staff to make clear to staff [Resident 2] was prohibited from sitting with or by or having any physical contact with any [fe/male] clients." "06/22/2024 at 11:43 AM [Officer] met with and interviewed [Resident 2]. ...[Resident 2] told me [s/he] had touched [Resident 1] over [his/her] clothing on [his/her] chest and by [his/her] [private area] on Thursday morning during the transport from [provider home] to [day program]. [Resident 2] said [s/he] had not asked [Resident 1] for permission to touch [him/her] anywhere, and [Resident 2] said [Resident 1] did not give [him/her] permission to touch [him/her]."	M 230		
M 290	88.05(3)(e)2.b INSPECTIONS-GAS FURNACE A gas furnace shall be inspected and serviced every 3 years by a heating contractor or local utility company. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the gas furnace was inspected and serviced every 3 years by a heating contractor or local utility company.	M 290		

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M 290	Continued From page 5 Findings include: On 07/30/2024, Surveyor requested the facility safety records. Surveyor noted an inspection dated 12/31/2019. Surveyor asked Home Coordinator A if there was a more recent furnace inspection. Home Coordinator A stated s/he was unsure of when the furnace was last inspected to ensure proper operating condition but would make contact with the vendor and forward the current documentation. On 07/31/2024 at 5:41 PM, Surveyor received an email from Home Coordinator A which stated the inspection had not been completed since 2019 and would be scheduled immediately.	M 290		
M 462	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 2 of 2 residents received the correct dosage of prescribed medications.	M 462		

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M 462	Continued From page 6 Resident 1 was prescribed as-needed (PRN) Acetamin but did not have specific physician orders defining dosage. Resident 3 was prescribed PRN Deep Sea (nasal spray) but did not have specific physician orders defining dosage. Findings include: On 07/30/2024, at approximately 4:00 PM, Surveyor and House Coordinator A observed Resident 1's and Resident 3's medications in the med closet. Example 1: Resident 1 Resident 1's medication bin included a blister card of Acetamin which documented, "1 to 2 tabs three x/day (times/day) as needed for pain." On 07/30/2024, at approximately 4:10 PM, Surveyor interviewed House Coordinator A. House Coordinator a stated s/he was unsure if the provider had documentation stating when Resident 1 was to take 1 tablet versus 2 tablets. Surveyor and House Coordinator A reviewed Resident 1's medication administration record (MAR) and individual service plan (ISP). Neither document outlined guidelines for the administration of the Acetamin. House Coordinator A stated s/he would request additional guidelines from Resident 1's primary physician. Example 2: Resident 3 Resident 1's medication bin included a bottle of Deep Sea nasal spray which documented, "Instill 2-4 sprays in each nostril as needed."	M 462		

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M 462	Continued From page 7 On 07/30/2024, at approximately 4:20 PM, Surveyor interviewed House Coordinator A. House Coordinator A stated s/he was unsure if the provider had documentation defining guidelines as to how many sprays should be administered to Resident 3. Surveyor and House Coordinator A reviewed Resident 3's medication administration record (MAR) and individual service plan (ISP). Neither document outlined guidelines for the administration of the Deep Sea. House Coordinator A stated s/he would request additional guidelines from Resident 3's primary physician.	M 462		
M 464	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain a written order from the physician who prescribed the medications, specifying who by name or position was permitted to administer the medication for 1 of 1 resident (Resident 1).	M 464		

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M 464	Continued From page 8 Findings include: On 07/30/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility, 03/21/2023, with diagnoses including intellectual disability, anxiety, mood disorder, oppositional defiant behavior and anorexia. Resident 1's April 2023 Medication Administration Record (MAR) identified staff had administered medication. Resident 1's "Authorization for Medications and Services," dated 03/14/2023, was signed by Resident 1's Guardian C. Resident 1's record did not contain a written order from the physician authorizing facility staff to administer medications. On 07/30/2024, at approximately 4:00 PM, Surveyor interviewed House Coordinator A. House Coordinator A confirmed staff administered Resident 1's medication upon admittance. House Coordinator A stated s/he was unaware that s/he needed authorization for medication administration from Resident 1's physician, but s/he would obtain the required documentation.	M 464		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g),	M 582		

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M 582	Continued From page 9 Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 1) received all prescribed medications from 03/21/2023 through 03/23/2023. Findings include: On 07/29/2024, the Department received a concern alleging that residents did not receive their prescribed medications upon admittance to the home. On 07/30/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility, 03/21/2023, with diagnoses including intellectual disability, anxiety, mood disorder, oppositional defiant behavior, GERD, and anorexia. Resident 1's pharmacy delivery manifest, dated 03/23/2023, documented the following medications were delivered at 5:34 PM: Clonidine (sedative and antihypertensive medication), Fiber-Lax, Folic Acid (Vitamin B), Omeprazole (stomach acid medication), Vitamin D3, Spironolactone (high blood pressure medication), Montelukast Sodium (asthma medication), Docusate Sodium (constipation medication), Atomoxetine (cognition-enhancing medication), Breo Ellipta (inhaler), Calcium, Risperidone (psychotropic), Cetirizine (allergy medication), Ondansetron (anti-nausea	M 582		

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M 582	Continued From page 10 medication), Ventolin (inhaler), and Naproxen (anti-inflammatory medication). Resident 1's March 2023 Medication Administration Record (MAR), dated 03/21/2023 to 03/24/2023, documented the prescribed medications were not administered 03/21/2023 and 03/22/2023. The MAR documented that medications were given at 8:00 AM and 4:00 PM on 03/23/2023 but the pharmacy delivery report stated the medications were not delivered until 5:30 PM. On 07/30/2024, at approximately 4:30 PM. Surveyor interviewed Home Coordinator B. Home Coordinator B stated when Resident 1 moved into the home s/he did not bring any medications with him/her from his/her previous assisted living home, and there had been complications getting the new physician orders set up with the pharmacy. Cross Reference: M0464 DHS 88.07(3)(d) Medication - Written Order	M 582		
M 610	88.11(1) REPORTING OF ABUSE AND NEGLECT A licensee or service provider who knows or has reasonable cause to suspect that a resident has been abused or neglected as defined in s. 46.90 or 940.285, Stats., shall immediately contact the licensing agency. Providing notice under this subsection does not relieve the licensee or other person of the obligation to report an incident to law enforcement authorities. If the	M 610		

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M 610	Continued From page 11	M 610		

licensee has reason to believe a crime has been committed, the incident shall immediately be reported to law enforcement authorities.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not immediately contact the licensing agency when s/he had reasonable cause to suspect abuse after being informed Resident 1 had been inappropriately touched by Resident 2.

Findings include:

On 07/23/2024, the Department received a complaint alleging a resident had been touched by another resident inappropriately.

On 07/30/2024, at approximately 3:45 PM, Surveyor interviewed Home Coordinator B. Home Coordinator B stated s/he had been contacted by Resident 1's Guardian C who informed him/her that Resident 1 told him/her that s/he had been touched inappropriately in the transport van by Resident 2 on 06/20/2024. Home Coordinator B stated s/he did not file a written report with the Department regarding this allegation.

Surveyor searched the facility record on file with the Department. The record did not contain a written report related to this allegation.

Cross Reference: M0230 DHS 88.04(2)(f) Condition Which Represents Risk or Harm