STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 10/18/2023, with information obtained through 10/27/2023, the Bureau of Assisted Living, Southern Regional Office, conducted a standard licensing survey at REM Harmony, an adult family home located in Madison, WI. As a result of the survey, 6 deficiencies were identified. Two deficiencies are repeat deficiencies. See Statement of Deficiency (SOD) 5CS611, dated 08/19/2021, SOD 5CS612, dated 12/08/2021, SOD IZEG11, dated 03/25/2022, SOD 5CS613, dated 09/29/2022, and SOD 5CS614, dated 02/06/2023. Census: 2	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 record review and interview, the provider permitted the existence and continuation of a condition in the home which placed the health and safety of residents at substantial risk of harm by having Caregiver G, who is not trained in first aid or fire safety, work shifts alone in the home. Findings include:	M 230		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 230	Continued From page 1	M 230		

The provider is licensed as an adult family home able to serve up to 4 adults within the client groups of physically disabled, developmentally disabled, traumatic brain injury, public funding, and irreversible dementia / Alzheimer's.

On 10/18/2023, at approximately 11:43 a.m., Surveyor toured the home with Program Supervisor A and Program Director B. Surveyor observed the food storage areas and observed they were all locked. Surveyor observed Program Supervisor A using a magnet lock to unlock each food cabinet observed. Surveyor asked if food was typically locked and for what reason. Program Supervisor A replied that food in the cabinets was typically locked due to Resident 1 because s/he would otherwise eat everything. At approximately 12:01 p.m., while touring the bathroom, Program Manager A replied that staff don't leave toilet paper out because Resident 1 is known to steal it, eat it, and use it to clog the toilet.

On 10/19/2023, Surveyor reviewed staff training records, provided by Area Director E. The record for Caregiver G, hired 09/15/2023, did not contain evidence that s/he was trained in fire safety or first aid.

On 10/19/2023, Surveyor reviewed the staff schedule, provided by Area Director E, and observed the following 18 occasions that Caregiver G was documented as working alone:

- 09/24/2023: 11:00 p.m. - 7:00 a.m. on 09/25/2023
- 09/25/2023: 11:00 p.m. - 7:00 a.m. on 09/26/2023
- 09/27/2023: 11:00 p.m. - 7:00 a.m. on 09/28/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 230	Continued From page 2 - 09/28/2023: 11:00 p.m. - 7:00 a.m. on 09/29/2023 - 09/29/2023: 11:00 p.m. - 7:00 a.m. on 09/30/2023 - 10/01/2023: 11:00 p.m. - 7:00 a.m. on 10/02/2023 - 10/02/2023: 11:00 p.m. - 7:00 a.m. on 10/03/2023 - 10/04/2023: 11:00 p.m. - 7:00 a.m. on 10/05/2023 - 10/05/2023: 11:00 p.m. - 7:00 a.m. on 10/06/2023 - 10/06/2023: 11:00 p.m. - 7:00 a.m. on 10/07/2023 - 10/07/2023: 11:00 p.m. - 7:00 a.m. on 10/08/2023 - 10/08/2023: 11:00 p.m. - 7:00 a.m. on 10/09/2023 - 10/09/2023: 11:00 p.m. - 7:00 a.m. on 10/10/2023 - 10/11/2023: 11:00 p.m. - 7:00 a.m. on 10/12/2023 - 10/12/2023: 11:00 p.m. - 7:00 a.m. on 10/13/2023 - 10/13/2023: 11:00 p.m. - 7:00 a.m. on 10/14/2023 - 10/16/2023: 11:00 p.m. - 7:00 a.m. on 10/17/2023 - 10/18/2023: 11:00 p.m. - 7:00 a.m. on 10/19/2023 On 10/19/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 09/18/2017 with diagnoses including unspecified focal traumatic brain injury. Resident 1 was documented as having a guardian and managed care organization (MCO) services. Surveyor reviewed Resident 1's most recent ISP, dated 09/25/2023, and observed a page titled "Choking Risk Assessment" which was dated as	M 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 230	Continued From page 3	M 230		

being completed on 09/13/2023. Within this page, the following was documented as predisposing characteristics that could lead Resident 1 to choke:

- A box titled "Impulsivity" was checked with the notes, "Eating too quickly, stuffing the mouth, take food from another's plate, eating off the counter at non-meal times."
- A box titled "Food pocketing" was checked with the notes, "Pocketing food in the cheeks, or the tendency for food to leak out of the mouth."
- A box titled "PICA" (a disorder characterized by eating non-food items) was checked with the notes, "The tendency to put non-food items into the mouth."

A section in this page, titled "Choking Risk Intervention Plan" documented, "Describe the specific techniques that staff has practiced so that each person will be ready to act, if there is a need to intervene in a choking situation." The documented reply was, "Staff are trained in First Aid and Conscious choking."

On 10/20/2023, at approximately 12:22 p.m., Surveyor interviewed Quality Improvement Specialist F. Quality Improvement Specialist F reported that s/he recognized the risk of Caregiver G working alone and not being trained in fire safety or first aid. Quality Improvement Specialist F reported s/he wanted to look at Caregiver G's training records to confirm whether or not s/he had training in either topic. Surveyor reported that any evidence for Caregiver G would need to be sent that day. Nothing further was received.

On 10/27/2023, at approximately 2:00 p.m., Surveyor interviewed Area Director E. Area

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 230	Continued From page 4 Director E acknowledged Surveyor's concern that Caregiver G was working alone but not trained in first aid or fire safety. Area Director E reported s/he thought that staff could work alone as long as they had been trained in standard precautions.	M 230		
M 246	88.04(5)(b) TRAINING-8 HOURS ANNUALLY Except as provided in pars. (c) and (d), the licensee and each service provider shall complete 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights and treatment of residents every year beginning with the calendar year after the year in which the initial training is received. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 2 of 2 staff reviewed completed 8 hours of training approved by the licensing agency related to the health, safety, welfare, rights, and treatment of residents every year beginning with the calendar year after the year in which the initial training was received. Caregiver C, who was hired 11/20/2017, completed 5 hours of continuing education in 2022. Caregiver D, who was hired 05/14/2015, completed 5 hours of continuing education in 2022. Findings include:	M 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 246	Continued From page 5 On 10/19/2023, Surveyor reviewed caregiver training records. Surveyor requested all training completed in 2022 for Caregivers C and D from Area Director E. The record for Caregiver C, hired 11/20/2017, documented 5 total hours of continuing education in 2022. The record for Caregiver D, hired 05/14/2015, documented 5 total hours of continuing education in 2022. On 10/20/2023, at approximately 12:22 p.m., Surveyor interviewed Quality Improvement Specialist F. Quality Improvement Specialist F acknowledged Surveyor's concern that both Caregivers C and D were short 3 hours of training in 2022, but said nothing further.	M 246		
M 276	88.05(3)(a) HOME ENVIRONMENT An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that the adult family home was maintained in a clean, homelike environment. This is a repeat deficiency. See Statement of Deficiency (SOD) 5CS611, dated 08/19/2021,	M 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 276	Continued From page 6 SOD 5CS612, dated 12/08/2021, SOD 5CS613, dated 09/29/2022, and SOD 5CS614, dated 02/06/2023. Findings include: On 10/18/2023, from approximately 10:51 a.m. - 11:09 a.m., Surveyor toured the environment and observed the following: - The left window in the living room was open with the screen down. The windowsill appeared covered in dirt, and small bits of debris and dead insects were observed (see Photo 1). - In the front entryway, 2 black horizontal stains were on the wall next to the front door, covering a total length of approximately 2.5 feet (see Photo 2). A 1x8" area below the black stains there appeared to have the paint chipped off. - In the front entryway, cobwebs were observed from the bench edge to the wall. A spider and dead insects were observed in the web (see Photo 3). At approximately 11:43 a.m., Surveyor showed the above concerns to Program Supervisor A and Program Director B. Program Supervisor A reported that the black wall stains and chipped paint were likely due to past residents' wheelchairs. However, Program Supervisor A confirmed with Surveyor that the current 2 residents were ambulatory (one with a walker, one without) and that the most recent third resident had discharged sometime around the beginning of summer. Both Program Supervisor A and Program Director B reported that the areas pointed out by Surveyor would be addressed.	M 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 276	Continued From page 7 At approximately 11:43 a.m., Surveyor continued to tour the environment with Program Supervisor A and Program Director B and observed the following: - In Resident 1's room, to the left of the window near the foot of the bed, 2 brown stains (1 measuring approximately 1x0.5" and the other measuring approximately 1x2") were on the wall (see Photo 4). Both Program Supervisor A and Program Director B reported that they weren't sure what the stains were. Program Director B reported that maybe it was food. - In Resident 1's room, the air register near the door appeared covered in dust (see Photo 5). Program Supervisor A reported that s/he typically cleans air vents but that this must have gotten missed. - In the laundry area in the basement, the area behind the dryer, including the back of the dryer itself, the bottom of the dryer vent (where the tubing connects to the dryer), and an electrical cord appeared covered in lint (see Photo 6). The floor space behind the dryer had a pile of lint built up. Program Supervisor A reported that s/he typically cleans behind the dryer and that sometimes the area can appear like that after just one week. On 10/27/2023, at approximately 2:00 p.m., Surveyor interviewed Area Director E. Area Director E reported that since Surveyor was on site, Program Supervisor A had worked on addressing all the areas of concern pointed out by Surveyor.	M 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 384	Continued From page 8	M 384		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 1 residents reviewed had a service agreement completed prior to admission to the home. Resident 2, who was admitted to the provider on 03/21/2023 until his/her hospitalization on 04/16/2023 and subsequent discharge from the provider, did not have a signed service agreement. Findings include: On 10/20/2023, Surveyor reviewed Resident 2's record, provided by Area Director E. Surveyor did not observe a service agreement within the record. On 10/20/2023, at approximately 12:22 p.m., Surveyor interviewed Quality Improvement Specialist F. Quality Improvement Specialist F confirmed that a service agreement for Resident	M 384		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 384	Continued From page 9 2 was not signed and that Resident 2 had passed away (after his/her hospitalization on 04/16/2023 and subsequent discharge from the provider) before a service agreement could be signed. Quality Improvement Specialist F acknowledged Surveyor's concern that a service agreement should have been completed prior to Resident 2 admitting to the provider.	M 384		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 1's individual service plan (ISP) was reviewed at least once every 6 months by the licensee, his/her guardian, and his/her placing agency.	M 424		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 424	Continued From page 10	M 424		

Resident 1's last ISP review with his/her guardian and his/her case manager appeared to be on 02/22/2022. Resident 1's ISP and behavioral support plan (BSP) did not identify his/her food-related and toilet paper-related behaviors, which warranted both to be secured from his/her access.

This is a repeat deficiency. See Statement of Deficiency (SOD) IZEG11, dated 03/25/2022.

Findings include:

On 10/18/2023, at approximately 11:43 a.m., Surveyor toured the home with Program Supervisor A and Program Director B. Surveyor observed the food storage areas and observed they were all locked. Surveyor observed Program Supervisor A using a magnet lock to unlock each food cabinet observed. Surveyor asked if food was typically locked and for what reason. Program Supervisor A replied that food in the cabinets was typically locked due to Resident 1 because s/he would otherwise eat everything.

At approximately 12:01 p.m., while touring the home, Surveyor observed the main bathroom. Surveyor observed that the toilet paper holder roller, with the roll of toilet paper was missing (see Photo 7). Surveyor asked Program Manager A if the roller was going to be replaced. Program Manager A replied that staff don't leave toilet paper out because Resident 1 is known to steal it, eat it, and use it to clog the toilet. Surveyor asked how Resident 1 was able to conduct toileting cares for him/herself if the toilet paper access was limited to him/her. Program Manager A replied that staff are typically with Resident 1 when s/he uses the bathroom to provide supervision, because Resident 1 also

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 424	Continued From page 11	M 424		

demonstrated behaviors of purposely defecating and urinating on him/herself, which staff had to monitor for and clean up after.

On 10/18/2023, Surveyor reviewed an ISP that was in the home for Resident 1, provided by Program Director B. The ISP was dated 09/26/2022 but had no evidence as being reviewed by anyone other than the provider's staff. At approximately 12:50 p.m., Surveyor interviewed Program Director B. Program Director B reported that a care meeting was coming up to discuss Resident 1's care plan updates and that it would take place sometime later this month. Surveyor requested all 2022 and 2023 ISP reviews for Resident 1, due 10/19/2023.

On 10/19/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 09/18/2017 with diagnoses including unspecified focal traumatic brain injury. Resident 1 was documented as having a guardian and managed care organization (MCO) services. Surveyor reviewed Resident 1's ISPs for 2022 and 2023, provided by Area Director E. Surveyor observed that the most recent ISP that was documented as being reviewed with Resident 1's guardian and his/her case manager was dated 02/22/2022. Surveyor reviewed ISPs dated 09/26/2022 and 09/25/2023 but did not observe evidence of them having been reviewed with Resident 1's case manager or guardian. On his/her ISP dated 09/26/2022, Resident 1 was identified as having a choking risk as well as a history of food seeking and overeating. On the same ISP, under the "Toileting" section, the following was documented: "[Resident 1] needs reminders to use the restroom throughout the day. Staff provide the necessary reminders to wash hands and to flush the toilet." Surveyor did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 424	Continued From page 12	M 424		

not observe any evidence of Resident 1's needs as related to restricting food and toilet paper access on any of the ISPs for Resident 1 provided.

On 10/20/2023, at approximately 12:45 p.m., Surveyor interviewed Guardian H, who was Resident 1's legal guardian. Guardian H reported that s/he served as Resident 1's guardian since October of 2022. Surveyor asked if s/he ever had a chance to review Resident 1's ISP in 2023. Guardian H replied that s/he had not. Guardian H reported that on 05/22/2023 there was a meeting where s/he had reviewed the MCO's care plan for Resident 1 but that s/he had to make a bunch of edits with crossing out certain pieces of information. Guardian H reported s/he didn't think the provider's ISP for Resident 1 was reviewed during that meeting. Surveyor asked if Guardian H was aware of any upcoming care meetings or conferences to discuss Resident 1's ISP. Guardian H replied that s/he was unaware of any. While talking with Surveyor, Guardian H reported that s/he looked through his/her calendar and did not see anything indicating a care meeting that was coming up for Resident 1.

On 10/27/2023, at approximately 2:00 p.m., Surveyor interviewed Area Director E. Area Director E reported that s/he recently had taken over for a previous area director and that s/he became aware that that area director had fallen behind on ISP reviews. Area Director E reported that Program Director B informed him/her that a care meeting was coming up for Resident 1 to review Resident 1's ISP. Surveyor reported to Area Director E that Guardian H didn't seem to be aware of any care meeting based on the earlier interview conducted with him/her. Area Director E replied that s/he would follow up with staff about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 424	Continued From page 13 it. When discussing Surveyor's concern that Resident 1's needs related to limiting food and toilet paper access did not seem to be documented on his/her ISP, Area Director B reported the information might be on Resident 1's BSP. On 10/27/2023, Surveyor reviewed Resident 1's most recent BSP, provided by Area Director E. Surveyor did not observe any information related to his/her limited food and toilet paper access.	M 424		
M 448	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 2's health was monitored in accordance with his/her bowel monitoring, diabetes complications monitoring, or when s/he experienced a change of condition on 04/16/2023, which caused him/her to be hospitalized. Resident 1 remained hospitalized until s/he was moved to hospice care on 05/01/2023 and passed away the same day. Findings include: On 10/19/2023, Surveyor reviewed the provider's record for Resident 2. Resident 2 was admitted to the provider on 03/21/2023 until his/her hospitalization on 04/16/2023. Resident 2's diagnoses included intellectual disability and type	M 448		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 448	Continued From page 14 II diabetes mellitus. Surveyor reviewed a document titled "Order Summary Report," which documented Resident 2's medical providers orders that were in place at the skilled nursing facility s/he resided at prior to his/her admission to the provider, dated 03/17/2023. Surveyor observed the following orders: - "[As needed (PRN)] glucose as needed Monitor glucose PRN for [signs and symptoms] of hypo/hyperglycemia." - "Accurate [bowel movement] documentation - Imperative Nursing to clear every shift three times a day." - "[Vitals] parameters, call [medical provider] if... [heart rate] >110, oxygen saturation <90...temperature >100.5." Surveyor reviewed a document titled "Health Passport" (not dated) which documented Resident 2's care needs. Surveyor observed the following within the document: - "I communicate using 2 hand signs. I am non-verbal. I am able to understand when someone asks me to do things and I can follow using: commands..." - "...Limit sugar, and carb intake as I am a diabetic." Surveyor reviewed an individual service plan (ISP) for Resident 2, dated 04/14/2023, and observed the following: - "Health Management" was documented as being one of Resident 2's needs - Within the activities of daily living section: "[Resident 2] is now diabetic, [his/her] blood	M 448		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 448	Continued From page 15	M 448		

sugar no longer has to be checked everyday[sic]. It is now a PRN."

Surveyor reviewed Resident 2's prescriptions, which included the following:

- Glutose 15 40% gel single dose (start date: 03/21/2023) with instructions to, "Take 1 tube as needed for glucose under 70."
- Milk of magnesia (start date 03/21/2023) with instructions to, "Take 30 mL by mouth one time daily as needed for constipation - use if no bowel movement for 3 days

Surveyor reviewed a document titled "[Bowel movement] Chart" which is where staff appeared to document Resident 2's bowel movements per shift during his/her admission. Within the document Surveyor did not observe any tracking completed from 04/01/2023 through 04/04/2023 and 04/15/2023. Resident 2's last bowel movement prior to his/her hospitalization was documented as occurring on second shift of 04/13/2023.

With regards to Resident 2's change of condition leading up to his/her hospitalization, Surveyor reviewed 2 incident reports which documented the following:

- 04/16/2023: "Staff reported to the on-call supervisor that [Resident 2] seemed weaker and wasn't wanting to eat. The on-call supervisor went to the house and determined that [s/he] should be seen in the [emergency room] and took [him/her] there. [Resident 2] was admitted and diagnosed with sepsis."
- 05/01/2023: "After [Resident 2]'s family decided to stop treatments for [him/her] on 4/27/23 [s/he] had been at [hospital]. On 5/1/23 [s/he] was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 448	Continued From page 16	M 448		

transferred to the in-patient [hospice facility]. We were notified by [his/her] guardian that [s/he] passed away at about 8:30pm that same day."

Surveyor reviewed shift summary notes for Resident 2 and observed an entry on 04/16/2023 at 3:42 p.m. (after Resident 2 was hospitalized) that documented, "[Resident 2] stay[sic] in the living-room[sic] to watch TV/movie and ask for coffee later." Entries from 04/13/2023 - 04/16/2023 did not document any health concerns for Resident 2.

On 10/20/2023, at approximately 12:22 p.m., Surveyor interviewed Quality Improvement Specialist F. When asked about the shift summary note on 04/16/2023, s/he reported that s/he thought the note was written in error. Surveyor asked if there was any additional information about Resident 2's weakness described in the incident report. Quality Improvement Specialist F replied that s/he thought the weakness was in relation to his/her transfers. When asked if there was any other health monitoring performed by and documented by staff regarding Resident 2's change of condition, Quality Improvement Specialist F reported s/he couldn't find any.

On 10/24/2023, at approximately 8:30 a.m., Surveyor interviewed Case Managers I and J, who were from Resident 2's managed care organization (MCO). Case Manager I reported that the initial report s/he received regarding Resident 2's hospitalization from the provider's staff was that Resident 2 was constipated and hadn't had a bowel movement in 1-2 days, however, hospital staff reported to him/her that it seemed like it was more like 4-5 days since Resident 2 had had a bowel movement. Case

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 448	Continued From page 17 Manager I reported that Resident 2 had historical issues with constipation and impaction and so routine bowel monitoring was expected from the provider's staff. Case Manager I reported that the importance of Resident 2's bowel monitoring was discussed around the time of his/her admission to the provider in a conversation between Former Area Director K, the skilled nursing facility's staff, Resident 2's guardian, and him/herself. On 10/27/2023, Surveyor reviewed outside medical records obtained for Resident 2, which included the following: 1) Regarding Resident 2's condition prior to admission to the provider: - Skilled nursing facility discharge summary, dated 03/17/2023: "...appears to be having [bowel movement] every 1-2 days." "Continue to monitor for [signs and symptoms] of hypo/hyperglycemia...Monitor glucose as needed for [signs and symptoms] of hypoglycemia." "Slow transit constipation" appeared to be one of Resident 2's addressed diagnoses while s/he was at the facility. - Skilled nursing facility clinical note dated 03/20/2023: "Spoke with [Resident 2's POA]...Reviewed that I am able to write for glucometer for PRN monitoring, if [Resident 2] were to have hypo/hyperglycemia symptoms. Reviewed that if these symptoms occurred and glucometer is not available that REM home would need notify [emergency medical services]." 2) Regarding Resident 2's 04/16/2023 hospitalization: - Emergency room admission note, dated	M 448		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 448	Continued From page 18	M 448		

04/16/2023, which documented that Resident 2's chief complaint was weakness and dyspnea (difficulty breathing). The note documented, "...presents to the emergency department with a chief complaint of weakness. The patient brought to care facility with concerns for increased weakness difficulty breathing since this morning....Of note, patient has activated [power of attorney] who reports history of cough and congestion since Thursday with gradually worsening symptoms..." The note documented that Resident 2 was hypoxic to 65% on room air which required 60 L of high-flow oxygen on 100%, that s/he was tachycardic (increased heart rate) with his/her heart rate in the 130s, that s/he was febrile with a temperature of 104.5° Fahrenheit, and that s/he was hyperglycemic with a blood glucose of 428. Resident 2's emergency room diagnoses included sepsis with acute hypoxic respiratory failure, hyperglycemia, diabetic ketoacidosis, and a non-ST elevated myocardial infarction (a type of heart attack).

- History and Physical exam, dated 04/16/2023: "[Resident 2's family] noted cough/congestion since Thursday 4/13. Patient lives in group home "Rem" - nurse [Nurse L] and supervisor [Former Area Director K]. In speaking with collateral, they note the above symptoms of respiratory symptoms. [Resident 2] was dropped off by a member of the group home at the [emergency room]."

- [Computed tomography (CT)] scan, dated 04/17/2023: "Large amount of stool within the rectum with wall thickening of the rectum and proximal sigmoid concerning for stercoral colitis/proctitus."

- Hospital discharge summary, dated 05/01/2023,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 448	Continued From page 19	M 448		

which documented that decision was made to terminally wean Resident 2 from his/her high flow nasal cannula and initiate comfort care measures with discharge to a local hospice inpatient facility.

On 10/27/2023, Surveyor reviewed e-mail correspondence between Case Manager I and Former Area Director K regarding Resident 2's change of condition, and observed the following:

- 1st e-mail, from Case Manager I, dated 04/19/2023: "I wanted to connect regarding concerns brought to my attention upon [Resident 2]'s arrival to the [emergency department] on Sunday. [Emergency department] staff noted that the REM staff who dropped [Resident 2] off did not know [Resident 2]'s name and was on [his/her] cellphone the entire time. Luckily [s/he] had [his/her] [do not resuscitate] bracelet for them to identify [him/her]. It's likely [s/he] should have brought in via ambulance, as [s/he] was in very critical condition..."

- E-mail response from Former Area Director K, dated 04/19/2023: "I will follow up with [him/her]. The staff actually did a great job of identifying an issue and getting [Resident 2] medical attention right away...[S/he] immediately reported to [Resident 2]'s home and decided to take [him/her] in for further evaluation. With the symptoms being so non-specific it would have been easy to have not taken [him/her] in. [S/he] should be commended for [his/her] actions."

- Additional e-mail from Former Area Director K, dated 04/19/2023: "[Resident 2]'s symptoms were pretty slight and non-specific and didn't indicate emergency treatment...Just on Friday with slight symptoms [Resident 2's family] felt [s/he] just needed allergy medication. I think most people

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 448	Continued From page 20	M 448		

would have waited and not taken [him/her] in at that point...I think the point here is that nobody would have probably taken [Resident 2] in sooner based on [his/her] symptoms and that our staff did an outstanding job of recognizing the slight changes and getting [him/her] care right away."

On 10/27/2023, at approximately 2:00 p.m., Surveyor interviewed Area Director E. Surveyor asked if there were any protocols or parameters the provider put in place for Resident 2's glucose monitoring, since it wasn't scheduled and seemed to only be indicated when Resident 2 was demonstrating symptoms of hypo/hyperglycemia. Area Director E reported s/he was unable to find any in Resident 2's record. Area Director E acknowledged Surveyor's concern that nothing else seemed to be assessed for Resident 2's change of condition on 04/16/2023, such as vitals or blood sugar. Area Director E reported that from his/her past work experience s/he was used to staff documenting more information, including vitals, when residents experienced changes of condition. Area Director E acknowledged Surveyor's concern that it wasn't clear what caregiving staff had assessed or observed as Resident 2's change of condition given the discrepancies in what they indicated Resident 2 was experiencing between the incident report (documenting weakness, to an unspecified degree, and meal refusal), hospital reports (in which they reported to hospital staff that Resident 2 was experiencing difficulty breathing and weakness), and the shift summary note (which did not identify any concerns regarding Resident 2's health). Area Director E acknowledged Surveyor's concern that it wasn't clear how staff, upon observing/assessing Resident 2's change of condition, determined Resident 2 was appropriate for their own hospital transport as opposed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 448	Continued From page 21	M 448		

warranting emergency medical services treatment, especially since the correspondence from Former Area Director K documented that Resident 2's symptoms didn't indicate any sort of emergency treatment. Area Director E reported that though s/he wasn't working with the provider when this incident occurred s/he instructs staff to typically request emergency medical services when residents experience changes of condition.

According to Mayo Clinic, symptoms of diabetic ketoacidosis can "come on quickly, sometimes within 24 hours" and include being weak or tired, being short of breath, and having a high blood sugar level (Mayo Clinic, Diabetic ketoacidosis, October 06, 2022, https://www.mayoclinic.org/diseases-conditions/diabetic-ketoacidosis/symptoms-causes/syc-20371551 (retrieval date - October 31, 2023).).

According to the National Institutes of Health (NIH), hypoxia occurs when "oxygen is not available in sufficient amounts at the tissue level...acutely, the hypoxia may present with dyspnea [difficulty breathing]." Severe hypoxia "can result in tachycardia [increased heart rate] to provide sufficient oxygen to the tissues," and compromised oxygenation can cause organ function to deteriorate. A resting oxygen saturation of less than 95% is considered abnormal, and the brain can develop changes when saturations are less than 80-85%. Pulse oximetry, a tool to measure oxygen saturation, "can provide a rapid tool to assess oxygenation accurately," and, "is extremely useful because the signs and symptoms of [low oxygen in the blood] may not be visible on physical examination," (Sources: National Institutes of Health: National Library of Medicine, Hypoxia, August 9, 2022, https://www.ncbi.nlm.nih.gov/books/NBK482316/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 448	Continued From page 22	M 448		

#:~:text=Hypoxia%20is%20a%20state%20in,in%20the%20blood%20(hypoxemia) (retrieval date - October 31, 2023); National Institutes of Health: National Library of Medicine, Oxygen saturation, November 23, 2022, https://www.ncbi.nlm.nih.gov/books/NBK525974/ (retrieval date - October 31, 2023).).

SUMMARY:
Record review of the provider's records for Resident 2 (which included skilled nursing facility medical provider orders for bowel monitoring and prescriptions indicating medications for use upon lack of bowel movements) as well as interview with Case Manager I indicated a known history of bowel concerns for Resident 2. However, between 03/21/2023 - 04/15/2023 (the day prior to Resident 2 admitting to the hospital), staff did not document Resident 2's bowel movements for a total of 5 days, including 4 consecutive days from 04/01/2023 - 04/04/2023.

Record review of the provider's records indicated known diabetes with ordered PRN blood glucose monitoring for Resident 2, however, as evidenced by interview with Area Manager E and lack of documentation, the provider did not establish parameters to guide staff in the monitoring of hypo/hyperglycemia or indications for testing Resident 2's blood glucose. On 04/16/2023, Resident's change of condition was marked by weakness, which can be a sign of diabetic ketoacidosis, a complication of hyperglycemia, and s/he was diagnosed with diabetic ketoacidosis upon admission to the emergency department that day.

Record review of hospital notes regarding Resident 2's hospitalization on 04/16/2023 indicate staff awareness of Resident 2's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013180	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM HARMONY	5333 KEVINS WAY MADISON, WI 53714

(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 448	Continued From page 23 respiratory symptoms, including by the staff who endorsed Resident 2's difficulty breathing since the morning, and historic symptoms reportedly endorsed by Former Area Director K in the hospital notes as well as in his/her e-mail communication with Case Manager I. However, there was no evidence that staff conducted any sort of assessment measures, such as vitals, for Resident 2 to determine whether Resident 2's condition was such that s/he could tolerate staff transport to the emergency department as opposed to receiving emergency medical services (EMS) treatment with transport. Upon admission to the emergency department, Resident 2 was found to have acute respiratory failure with an oxygen saturation of 65% as well as diabetic ketoacidosis.	M 448		