| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0010524 | A. BUILDING: _____ B. WING _____ | R-C 06/07/2024 |

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| {N 000} | Initial Comments<br><br>On 06/06/2024, with information gathered through 06/07/2024, Surveyor conducted a standard survey, a complaint investigation, and a verification visit. As a result, the previous deficiencies were corrected, and 3 new deficiencies were identified.<br><br>One of 3 deficiencies was a repeat violation (see Statement of Deficiency QO0Y12, dated 09/26/2019).<br><br>The complaint was unsubstantiated.<br><br>Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed.<br><br>Census: 8 | {N 000} | | |
| N 404 | 83.37(1)(e) Medication regimen, administration review.<br><br>Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report | N 404 | | |

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

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| N 404 | Continued From page 1<br>when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure an annual review of their medication administration practices for 2 of 2 years reviewed (2022 and 2023). The annual review was completed by a pharmacist and did not include a medication administration review.<br><br>Findings include:<br><br>On 06/06/2024, Surveyors reviewed medication system review documentation provided by Operations Manager A. The following was identified:<br>-Medication Room/Station Inspection, dated 07/11/2024, did not include a review of the medication administration system. The document recorded an audit of the medication room by a pharmacist.<br>-Medication Room/Station Inspection, dated 07/12/2024, did not include a review of the medication administration system. The document recorded an audit of the medication room by a pharmacist.<br><br>On 06/06/2024, at 3:30 PM, Surveyor interviewed Director of Nursing E and Operations Manager A. Operations Manager A reported s/he believed the pharmacist completed a medication pass observation to assess their medication administration system. Operations Manager E reported s/he would contact the pharmacy and provide documentation if s/he received it. As of 06/07/2024, at 5:00 PM, Surveyor had not | N 404 | | |

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| N 404 | Continued From page 2<br>received documentation indicating the medication administration system was reviewed in 2022 and 2023. | N 404 | | |
| N 483 | 83.43(2)(b) Clean, comfortable mattress and pad.<br><br>Bedroom furnishings. If a resident does not provide the resident ' s own bedroom furnishings, the CBRF shall provide all of the following: A clean, comfortable mattress covered with a mattress pad and when necessary, waterproof covering.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure 1 of 1 resident received a clean mattress when theirs had tears. Resident 1 had urine incontinence and his/her bed smelled of urine. Surveyor observed several cracks in the vinyl covering of the mattress, exposing the foam underneath.<br><br>This is a repeat deficiency. See Statement of Deficiency QO0Y12, dated 09/26/2019.<br><br>Findings include:<br><br>On 06/06/2024, at approximately 12:20 PM, Surveyor observed Resident 1's bedroom with Operations Manager A. Resident 1's room smelled of urine. The urine smell was stronger when next to Resident 1's bed. Operations Manager A removed Resident 1's bedding. The mattress, which was constructed with a vinyl top and outer layer, contained several cracks in the vinyl, which exposed the yellow foam under it.<br><br>On 06/06/2024, at approximately 12:20 PM, | N 483 | | |

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| N 483 | Continued From page 3<br><br>Surveyor interview Operations Manager A. Operations Manager A reported Resident 1 had urine incontinence. Operations Manager A confirmed Resident 1's room smelled of urine and reported they had been attempting to have the managed care company provide a new mattress for several weeks, without success. Operations Manager A confirmed Resident 1's mattress was the likeliest source of the urine smell throughout the room. Operations Manager A reported s/he would let the administrator and licensee know to replace the mattress. | N 483 | | |
| N 490 | 83.44(2)(b) Toilet and bathing area.<br><br>All toilet and bathing areas, facilities and fixtures shall be clean and in good working order.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure toilet and bathing areas were clean for 8 of 8 residents. The individual resident bathrooms and the common shower room were in need of cleaning.<br><br>Findings include:<br><br>On 06/06/2024, at approximately 11:30 AM to 12:30 PM, Surveyor toured the physical environment and observed the following:<br><br>Shower room (used by all residents)<br>-The flooring was tile, which had several brownish stains on it.<br>-There was a 2-inch-wide ring on the flooring around the outer edge of the shower room which was darkened. Upon wiping it with a paper towel, Surveyor observed black debris consistent with dirt and dust on the paper towel. | N 490 | | |

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| N 490 | Continued From page 4<br>-The shower had what appeared to be soap scum on the bottom of it.<br>-The shower mat was had the appearance of a brownish film on it. When flipped over, one of the long edges and one short edge exhibited blackened slimy spots consistent with mud and mold.<br><br>Resident 5's bathroom<br>-Wall had black scuff marks along the bottom part near the trim and up to the toilet paper holder.<br>-There was no toilet paper available.<br>-The plunger was located next to the toilet and had specks of white on it consistent with dried toilet paper.<br>-The cleaning brush was laying down behind the toilet.<br>-There was a dark brownish, black ring around the interior of the toilet, approximately 1/2 inch to ¾ inch wide.<br>-The toilet seat finish was worn in the back area and on the right side, which exposed the material it was made of underneath. The toilet seat had specks of brown and gray consistent with dried feces and ashes from a cigarette.<br>-There were liquid spots on the floor in front of the toilet which had a dark ring around them and appeared to be dried and stained.<br>-There were black and gray specks around the counter, consistent with cigarette ashes and burn marks.<br><br>Resident 6's bathroom<br>-The floor had stains around the toilet, which appeared darker all around than the other flooring made of the same material in the bathroom.<br>-There were brown stains around the rim of the toilet, on the toilet seat and toilet tank, and the toilet seat consistent with urine and feces. | N 490 | | |

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| N 490 | Continued From page 5<br><br>On 06/06/2024, at approximately 12:15 PM, Surveyor interviewed Operations Manager A. Operations Manager A reported each resident required assistance with cleaning their bathrooms. Operations Manager A reported there was a task log in their computer system to ensure each residents' bathroom was cleaned on a schedule, but it was different for each resident depending on their needs with personal care. Operations Manager A reported it was the Caregivers' responsibility to ensure all bathrooms were cleaned and if they saw something that needed cleaning outside of the scheduled times, they were responsible for completing the task. Operations Manager A confirmed Resident 4 5 smoked in his/her bedroom on occasion. Operations Manager A reported s/he would reeducate staff on their responsibilities. | N 490 | | |