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N 000	Initial Comments On 10/31/2023, Surveyor conducted a standard survey at Grace Commons II. Eight deficiencies were identified. Census: 20	N 000		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all resident care staff reviewed received at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment including at a minimum all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. Two of 2 employees reviewed did not meet the	N 277		

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

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N 277	Continued From page 1 required 2022 continuing education requirements. Findings include: The facility is licensed as a Class CNA CBRF able to serve up to 24 residents within the client groups of advanced age, terminally ill, irreversible dementia/Alzheimer's, and physically disabled. On 10/31/2023, Surveyor reviewed employee records for Lifestyle Enrichment Assistant E and Lead Caregiver F. Example 1- Lifestyle Enrichment Assistant E Lifestyle Enrichment Assistant E was hired 03/10/2021. His/her employee record contained no 2022 continuing education. Example 2- Lead Caregiver F Lead Caregiver F was hired 05/05/2021. His/her employee record contained training in "Emergency Plan" dated 07/26/2022. Duration of training was not documented. Lead Caregiver F's employee record contained no additional 2022 continuing education. On 10/31/2023 at 1:03 PM, Surveyor interviewed Executive Director A who stated Lifestyle Enrichment Assistant E's annual training was not completed because, due to a glitch in the system, training was not assigned to him/her. Executive Director A provided Surveyor with an email from Operations Specialist G to Assistant Executive Director C dated 10/31/2023 and time stamped 12:06 PM. The email stated " ...I see that [Lifestyle Enrichment Assistant E] wasn't assigned any for 2022. We had a [sic] issue that we have now corrected starting in 2023, that new hires were being assigned after a full calendar year instead of a year of service. Did you have	N 277		

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N 277	Continued From page 2 any in person in-services that you can recall from 2022, that you can give the State as training documents?..." On 10/31/2023 at 4:01 PM, Surveyor discussed concern of 2022 continuing education not completed with Executive Director A, RN B, and Assistant Executive Director C. Executive Director A stated Caregiver E's 2022 continuing education was also not completed for same reason as Life Style Enrichment Assistant E's. Executive Director A stated the system has since been fixed and all required 2023 continuing education would be completed.	N 277		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure an assessment for the use of siderails was completed. Resident 6's bilateral 1/2 siderails were not	N 381		

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N 381	Continued From page 3 assessed. Findings include: According to the U.S. Food & Drug Administration's Hospital Bed Safety Workgroup, "...Strangling, suffocating, bodily injury, or death can occur when patients or parts of their bodies are caught between rails or between the bed rails and mattresses...Regardless of the purpose for which bed rails are being used or considered, a decision to utilize or remove those in current use should occur within the framework of an individual patient assessment. 2. Because individuals may differ in their sleeping and nighttime habits, creation of a safe bed environment that takes into account patient's medical needs, comfort, and freedom of movement should be based on individualized patient assessment by an interdisciplinary team...3. Use of bed rails should be based on patient's assessed medical needs and should be documented clearly...Bed rail effectiveness should be reviewed on a regular basis...The patient's chart should include a risk-benefit assessment that identifies why other care interventions are not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the patient. 4. Bed rail use for treatment of a medical symptom or condition should be accompanied by a care plan (treatment program) designed for that symptom or condition. The plan should present clear directions for further investigation of less restrictive care interventions. The documentation should describe the attempts to use less restrictive care interventions and, if indicated, their failure to meet patient's assessed needs. 5. Bed rail use for patient's mobility and/or transferring, for example turning and positioning	N 381		

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within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan...The care plan should: include educating the patient about possible bed rail danger to enable the patient to make an informed decision; and address options for reducing the risks of the rail use. 6. The process of reducing and/or eliminating existing use of bed rails should be undertaken incrementally using an individualized, systematic, and documented approach..." (Source: "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings" https://www.fda.gov/media/88765/download (retrieval date 11/01/2023)).

On 10/31/2023 at 9:24 AM, Surveyor observed Caregiver D transfer Resident 6 into bed. Attached to the bed were bilateral ½ siderails. The bed was situated next to a wall with the wall side rail in the up position. Caregiver D put the room side of the bed's siderail up once Resident 6 was situated in bed.

On 10/31/2023 at 9:25 AM, Surveyor interviewed Caregiver D who stated the siderails were used to prevent Resident 6 from falling out of bed and Resident 6 did not roll or move in bed independently. Caregiver D stated the siderails were on the bed and used since Resident 6's admission. Caregiver D stated staff put the siderail on the room side of the bed up whenever Resident 6 was in bed.

On 10/31/2023 at 10:05 AM, Surveyor requested Resident 6's record including most recent comprehensive assessment.

On 10/31/2023, Surveyor reviewed Resident 6's

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record. S/he was admitted 06/02/2023. Diagnoses included history of subdural hematoma and cervical spondylosis myelopathy (damage to the spinal cord in the neck).

Assessment dated 10/17/2023 (summarized): Required Hoyer lift transfer and Broda chair for mobility.
In the area of Mobility, Transport and Escort- " ...Do you use a bedside mobility device Yes ...Resident uses bedside mobility device-indicate what the device is. Resident's Desired Goals & Outcomes: To safely use the bedside mobility device. Service Providers Responsibilities: Daily thru next review ..."
The assessment did not identify use of or reason for siderails.

Individual Service Plan (ISP) dated 10/26/2023:
In the area of Bedside Mobility Device- "If bedside mobility device is used indicate what it is ...Resident uses bedside mobility device- indicate what the device is ...to safely use the bedside mobility device ...Daily through next review ..."
The ISP did not identify use of or reason for siderails.

On 10/31/2023 at 2:52 PM, Surveyor interviewed Executive Director A who stated staff turned Resident 6 onto his/her side then s/he held onto the siderail to maintain side lying position during cares. Executive Director A stated the siderails were on the bed on admission as continuation of a pre-admission care plan. Executive Director A stated s/he would ask RN B for the siderail assessment. A few minutes later, Executive Director A informed Surveyor there was no formal assessment for Resident 6's side rails.

On 10/31/2023 at 4:01 PM, Surveyor discussed

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N 381	Continued From page 6 concern of no assessment for Resident 6's bilateral ½ siderails with Executive Director A, RN B, and Assistant Executive Director C. RB B stated Resident 6 Based on observation, record review and interview, the provider did not ensure an assessment for the use of side rails was completed.	N 381		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure when a psychotropic medication was prescribed on an as needed basis for a resident, the resident's individual service plan included the rationale for use and a	N 408		

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N 408	Continued From page 7 detailed description of the behaviors which indicated the need for administration of PRN psychotropic medication. Resident 7's ISP did not include the rationale for use and a detailed description of the behaviors indicating the need for administration of PRN Alprazolam. Findings include: Per DHS 83.02(41) "Psychotropic medication means a prescription drug, as given in s. 450.01 (20), Stats., that is used to treat or manage a psychiatric symptom or challenging behavior". On 10/31/2023, Surveyor reviewed Resident 7's record. S/he was admitted 06/16/2021. Physician orders included Alprazolam 0.5 MG 1 tablet at bedtime and Alprazolam 0.5 MG 1 tablet as needed if first dose not effective. Individual Service Plan (ISP) dated 10/16/2023: In the area of Antipsychotic Medication- "Directions: Be alert to new or worsening drowsiness, new or worsening dizziness, new or worsening confusion, new or worsening restlessness, new or worsening nausea/vomiting ...Resident receives antipsychotic medications, staff should be aware of behavior and response to these mediations. Resident's Desired Goals and Outcomes: To receive my medication, and have mood or behavior stabilize..." In the area of Benzodiazepine- "Directions: Be alert to drowsiness, new or worsening lightheadedness, change in in gait/walking, new or worsening slurred speech, new or worsening muscle weakness, new or worsening confusion. Resident may take PRN dose ...Resident receives benzodiazepine medications ...	N 408		

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N 408	Continued From page 8 Resident's Desired Goals and Outcomes: To receive my medication ...daily through next review ..." In the area of Demonstrate Anxious Behavior Requiring Additional Attention- " ...Resident experiences anxious behavior and needs gentle redirection and reassurance to calm and feel less stressed. Signs of stress may include, pacing, crying, wringing hands, calling out. Staff sit quietly with resident, talk quietly in calm voice, offer gentle reassuring touch on hand or arm. Check for pain/discomfort, use SDD to determine trends related anxiety, reduce stressful situations by creating calm and predictable environment. Remove resident from congested and/or disruptive environments. Resident's Desire Goals & Outcomes: To have help working through anxiety ...daily thru next review ..." On 10/31/2023 at 4:01 PM, Surveyor discussed concern that rationale for use and detailed description of behaviors for PRN Alprazolam was not identified on Resident 6's ISP with Executive Director A, RN B, and Assistant Executive Director C. RN B stated Resident 6 was discharged from hospice services, and the PRN Alprazolam was a hospice comfort medication. RN B stated Resident 6 did not take the PRN Alprazolam and s/he would get it discontinued.	N 408		
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 medication administration, the person administering the medication or treatment shall document in the resident record the name,	N 415		

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N 415	Continued From page 9 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 observation, record review and interview, the provider did not ensure staff documented medication administration correctly on the medication administration record. Staff documented Resident 5 had declined medication when it was held due to systolic (top number) blood pressure (BP) >120. Findings include: On 10/31/2023 at approximately 8:45 AM, Surveyor observed Caregiver D take Resident 5's blood pressure. Caregiver D told Resident 5 the Midodrine would be held because the systolic blood pressure was 140. Resident 5 stated "That's right." On 10/31/2023 at approximately 8:45 AM, Surveyor interviewed Caregiver D who stated s/he held Resident 5's Midodrine because blood pressure was 140/72 and Midodrine was to be held when systolic blood pressure was >120. On 10/31/2023, Surveyor reviewed Resident 5's record. S/he was admitted 08/24/2020. Physician orders included Midodrine 5 MG 1 tablet three times daily before meals- hold for systolic blood pressure <120 (start date 08/31/2023).	N 415		

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October 2023 medication administration record (MAR):
On 10/31/2023 Caregiver D documented on Resident 5's MAR that Midodrine 5 MG was "Declined by resident" at 7:54 AM. Blood pressure 140/72.

Additionally, staff documented Midodrine 5 MG was "Declined by resident" when systolic blood pressure was >120 on the following dates and times:
10/04/2023- 11:31 AM
10/07/2023- 8:08 AM
10/11/2023- 9:52 AM
10/24/2023- 8:05 AM
10/24/2023- 12:14 PM
10/26/023- 7:38 AM
10/26/2023- 11:51 AM
10/30/2023- 9:08 AM

Staff documented administration of Midodrine 5 MG when systolic blood pressure was >120 on the following dates and times:
10/01/2023- 9:13 AM, BP 130/71
10/03/2023- 7:56 AM, BP 135/76
10/08/2023- 7:49 AM, BP 139/74
10/08/2023- 12:18 PM, BP 131/70
10/09/2023- 9:07 AM, BP 135/78
10/11/2023- 1:16 PM, BP 152/77
10/13/2023- 8:06 AM, BP 146/66
10/13/2023- 11:39 AM, BP 137/70
10/17/2023- 9:14 AM, BP 165/83
10/18/2023- 9:19 AM, BP 127/66
10/21/2023- 9:25 AM, BP 125/66
10/29/2023- 11:43 AM, BP 156/83, documented by Caregiver H.

On 10/31/2023 at 2:17 PM, Surveyor interviewed Caregiver H. Surveyor reviewed Resident 5's October 2023 MAR with Caregiver H. Caregiver

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N 415	Continued From page 11 H identified s/he had documented administration of Midodrine 5 MG at 11:43 AM on 10/29/2023. Caregiver H stated s/he should have documented "no pass per vitals" because s/he held the Midodrine due to systolic blood pressure >120. On 10/31/2023 at 2:26 PM, Surveyor interviewed RN B who stated when Resident 5's systolic blood pressure is >120, staff need to document "no pass per vitals" on the MAR. RN B stated staff knew how to correctly document when Resident 5's Midodrine was held because s/he always trained staff medication administration with Resident 5 because of the blood pressure parameter with the Midodrine. On 10/31/2023 at 4:01 PM, Surveyor discussed concern of staff not documenting medication administration correctly with Executive Director A, RN B, and Assistant Executive Director C. RN B stated they would retrain staff. RN B stated Resident 5 was very aware of and involved with his/her medication and blood pressures and would not decline his/her medication.	N 415		
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 and interview, the provider did not ensure employees followed hand washing procedures according to Centers for Disease Control and Prevention Standards (CDC). Caregiver D did not wash or sanitize his/her hands between resident's medication	N 441		

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administration or after assisting residents with cares during medication administration. Caregiver D administered a dropped medication after picking it up off the medication cart's surface, administered water with a cup s/he had touched the rim of without first washing or sanitizing hands, and donned a glove after picking it up off the floor.

Findings include:

According to CDC, "Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. Perform hand hygiene immediately after removing gloves. (Source: https://www.cdc.gov/handhygiene/providers/index.html (retrieval date 11/01/2023)).

On 10/31/2023 at 8:39 AM, Surveyor observed Caregiver D assist Resident 1 while coughing by patting Resident 1's back. Without washing or sanitizing his/her hands, Caregiver D began prepping Resident 2's medications. Caregiver D donned gloves, finished prepping Resident 2's medications, and documented the prepped medications on the lap top. At 8:49 AM, Caregiver D took Resident 2's blood pressure and administered Resident 2's medications. Caregiver D removed gloves and documented administration of Resident 2's medications on the laptop.
At 8:57 AM, without washing or sanitizing his/her

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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 441	Continued From page 13	N 441		

hands, Caregiver D answered Resident 3's call light and touched Resident 3 and his/her breakfast setting while looking for a lost cookie. Caregiver D returned to the medication cart, and without washing or sanitizing his/her hands Caregiver D prepped Resident 3's medications. Caregiver D dropped a Sertraline 50 MG tablet onto the medication cart surface, picked it up with his/her fingers and put it into the medication cup with Resident 3's other medications. At 9:01 AM, when Caregiver D pulled 2 gloves out of a box of gloves, 1 glove fell on the floor. Caregiver D picked the glove off the floor, donned the dropped glove then administered Resident 3's medications.
At 9:04 AM, Caregiver D took gloves off. Without washing his/her hands, Caregiver D donned gloves then used a sit-to-stand lift to transfer Resident 3 onto the toilet. Caregiver D took gloves off and documented administration of Resident 3's medications on the laptop.
At 9:13 AM, without washing or sanitizing his/her hands, Caregiver D began prepping Resident 4's medications. Caregiver D tipped over an empty water glass onto the medication cart surface. Caregiver D touched the water cup's rim with his/her hand to upright it. Caregiver D poured water into the cup then donned gloves. Caregiver D administered Resident 4's medications along with the water in the cup. Caregiver D took gloves off and documented administration of Resident 4's medications on the laptop.

On 10/31/2023 at approximately 9:30 AM, Surveyor interviewed Caregiver D who stated s/he did not wash or sanitize his/her hands during the medication pass because "Normally there's hand sanitizer on the cart but not today."

On 10/31/2023 at 4:01 PM, Surveyor discussed

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	0018200	A. BUILDING: _____ B. WING _____	11/03/2023

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N 441	Continued From page 14 concern of infection control with Executive Director A, RN B, and Assistant Executive Director C. RN B stated the expectation is that staff will sanitize or wash their hands between each resident's cares and medication pass and staff should replace dropped medications with medications from the end of the month and destroy the dropped medication.	N 441		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all dryers were vented with rigid material. One of 2 dryers observed was vented with flexible tubing. Findings include: On 10/31/2023 at 3:53 PM while touring facility with Executive Director A, Surveyor observed 2 dryers in the laundry room. One dryer was vented with flexible tubing (Photo 1). On 10/31/2023 at 4:01 PM, Surveyor discussed concern of flexible dryer venting with Executive Director A, RN B, and Assistant Executive Director C. Executive Director A stated s/he was unaware how long the flexible venting had been on the dryer and they would get it replaced as	N 488		

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N 488	Continued From page 15 soon as possible. 11/01/2023 at 2:26 PM, Surveyor emailed Executive Director A stating " ...Regarding the dryer vent: If the flexible vent meets the UL 2158A listing requirements and the flexible dryer vent is approved for use by the dryer's manufacturer then it would be okay. If it meets the requirements send me: A picture of the make and model of the dryer, a picture of the UL2158A listing requirement on the vent, and documentation the vent is approved for use by the dryer manufacturer..." On 11/03/2023 at 1:07 PM, Surveyor received an email from Executive Director A stating "...The recommendation from the manufacturer is rigid venting unless a flexible adapter is installed..."	N 488		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours.	N 525		

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N 525	Continued From page 16	N 525		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure fire evacuation drill were conducted at least quarterly with at least 1 drill simulating conditions during usual sleeping hours.

One fire drill was conducted during 2022. The drill did not simulate conditions during usual sleeping hours.

Findings include:

On 10/31/2023, Surveyor reviewed 2022 fire drill documentation.
A fire drill was conducted on 03/28/2022 at 10:00 AM. The drill did not simulate conditions during usual sleeping hours. No additional drills were documented during 2022.

On 10/31/2023 at 11:44 AM, Surveyor interviewed Executive Director A who stated only 1 fire drill in 2022 may have been due to the transition of maintenance leadership in September 2022.

On 10/31/2023 at 4:01 PM, Surveyor discussed concern of only 1 fire drill conducted during 2022 and no fire drills simulating usual sleeping hours during 2022 with Executive Director A, RN B, and Assistant Executive Director C. Executive Director A stated it was probably due to the transition of maintenance leadership in September of 2022 and they would ensure all required drills were conducted in 2023.

Cross Reference:
N0526 DHS 83.47(2)(e) Other Evacuation Drills

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N 526	Continued From page 17	N 526		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure tornado, flooding, or other emergency or disaster evacuation drills were conducted at least semi-annually. On 10/31/2023, Surveyor reviewed 2022 tornado, flooding, or other emergency or disaster evacuation drills. A tornado drill was conducted on 06/09/2022. No additional drills were documented during 2022. On 10/31/2023 at 11:44 AM, Surveyor interviewed Executive Director A who stated only emergency evacuation drill in 2022 may have been due to the transition of maintenance leadership in September 2022. On 10/31/2023 at 4:01 PM, Surveyor discussed concern of only 1 other evacuation drill conducted during 2022 with Executive Director A, RN B, and Assistant Executive Director C. Executive Director A stated it was probably due to the transition of maintenance leadership in September of 2022 and they would ensure all required drills were conducted in 2023. Cross Reference: N0525 DHS 83.47(2)(d) Fire Drills	N 526		