STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012868	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONS	**16208 WOODRIDGE LN HAYWARD, WI 54843**

(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 000	Initial Comments On 11/07/2024, Surveyor conducted an abbreviated licensure survey at Transitions. Five deficiencies were identified. Census: 6	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 employees sampled were screened for communicable disease, including tuberculosis (TB) per the Centers for Disease Control and Prevention (CDC) standards. Findings include: The Department of Health Services publication Tuberculosis Screening and Testing: Health Care	N 220		

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

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N 220	Continued From page 1 Personnel (HCP) and Caregivers (including assisted living staff) states: "Perform baseline testing for all HCP and caregivers without documented evidence of prior LTBI [latent tuberculosis] or TB disease... IGRA [blood test] or TST [tuberculin skin test] may be performed; IGRA is preferred... If TST is used as the baseline testing, 2-step testing is recommended for HCP and caregivers who have not had TST testing previously or have only had one negative TST test greater than 12 months ago. If 2 or more TST tests have been previously performed, all results are negative, and documentation of results is available, a one-step TST may be performed before hire." (Retrieved 2/22/2023 from https://dhs.wisconsin.gov/publications/p02382.pdf) On 11/07/2024, Surveyor reviewed employee records. HM A was hired on 08/05/2024, Staff C was hired on 10/31/2023, and Staff D was hired on 08/21/2022. Each record included a 1-step TST result. None of the records included evidence the employees were screened for other communicable illnesses. At 11:37 AM, Surveyor interviewed Director B. Director B stated new employees obtained a TB test prior to working on site. Director B said s/he or the human resources department review the results. Director B stated s/he believed they were obtaining 2-step TST because their process involved 2 appointments (1 to inject and 1 to read the results). Director B stated s/he was not aware employees needed to be screened for other communicable diseases. Director B said s/he had continued the system the previous director had in place.	N 220		

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N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 employees sampled, House Manager (HM) A, completed orientation training. Findings include: On 11/07/2024, Surveyor reviewed HM A's record. HM A was hired on 08/05/2024. His/her record did not include evidence of orientation training. At 11:30 AM, Surveyor interviewed HM A and Director B. HM A discussed his/her training experience since hire, which did not include training on abuse, neglect, and misappropriation, or recognizing and responding to changes in condition. HM A reviewed his/her records and stated s/he	N 230		

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N 230	Continued From page 3 did not have documentation of orientation training. HM A stated s/he created a new employee training checklist that s/he planned to use going forward. Surveyor reviewed the training checklist. The revised training plan did not include all required orientation topics. Surveyor provided technical assistance and Director B stated, "I can see where we are missing things."	N 230		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drills were conducted at least quarterly.	N 525		

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N 525	Continued From page 4 Findings include: The provider is licensed to care for 8 residents in the client groups emotionally disturbed/mental illness and alcohol/drug dependent. On 11/07/2024, Surveyor reviewed the provider's safety records, which indicated the provider conducted 3 fire drills in 2022, 2 fire drills in 2023, and 3 between January and May 2024. At 10:40 AM, Surveyor interviewed House Manager (HM) A. HM A stated fire drills were supposed to be done quarterly. HM A stated s/he was new to the position and planned to create a schedule to ensure drills were completed.	N 525		
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 "other" emergency evacuation drills were conducted semi-annually. Findings include: The provider is licensed to care for 8 residents in the client groups emotionally disturbed/mental illness and alcohol/drug dependent. On 11/07/2024, Surveyor reviewed the provider's safety records, which indicated the provider conducted 1 severe weather drill in 2021, 1 in 2022, 3 in 2023, and 1 in 2024 (on 04/11/2024).	N 526		

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N 526	Continued From page 5 At 10:40 AM, Surveyor interviewed House Manager (HM) A. HM A stated the provider conducted 2 kinds of drills - fire and severe weather. HM A said it was the provider's policy to conduct severe weather drills quarterly. HM A stated s/he was new to the position and planned to create a schedule to ensure drills were completed.	N 526		
N 639	83.59(2)(a) One-hand, one-motion door operation All doors shall have latching hardware to permit opening from the inside with a one-hand, one-motion operation without the use of a key or special tool. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all doors had one-hand, one-motion (1H1M) locks. The 3 exits were equipped with deadbolt locks that did not unlock with 1H1M. Findings include: On 11/07/2024 at approximately 10:30 AM, Surveyor toured the facility with House Manager (HM) A. Surveyor observed the first exit had a deadbolt lock. HM A stated all 3 exit doors had the same locking mechanisms. At approximately 12:15 PM, Director B was discussing the need to replace the locks with Nurse E. Nurse E and Director B discussed how they had recently replaced the doors and they were not aware the locks were not compliant with the regulations.	N 639		

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