STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017968	A. BUILDING: _____ B. WING _____	R-C 02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERGEN MANOR CBRF	522 WEST BERGEN DRIVE FOX POINT, WI 53217

(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 02/22/2024, Surveyors completed a standard survey, verification visit, and 2 complaint investigations at Bergen Manor CBRF. Seventeen deficiencies were identified. Seven of the 17 deficiencies were repeat violations. See statement of Deficiency (SOD) CUOK11, dated 09/20/2021; SOD CUOK12, dated 05/10/2022; SOD CUOK13, dated 05/23/2023. One complaint was substantiated. One complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 8	{N 000}		
{N 196}	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not comply with all laws governing the Community Based Residential Facility (CBRF), as evidenced by 17 deficient practices. The licensee did not ensure compliance with DHS 83 was achieved and maintained. As a result of this verification visit, 2 complaint investigations, and a standard survey, a total of 17 violations were issued. Seven of 17 violations were repeat deficiencies related to licensee	{N 196}		

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

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{N 196}	Continued From page 1 ensures facility complies with laws; medication storage: locked cabinet; food safety; environment safe, clean, and comfortable; unsecured toxic substances; fire extinguishers: type and inspection; and proper exit locations, sidewalks, driveways. This deficiency is being cited for a 4th time. See Statement of Deficiency (SOD) CUOK11, dated 09/20/2021, SOD CUOK12, dated 05/10/2022, and SOD CUOK13, dated 05/23/2023. Findings include: The provider is licensed as a Class CNA (non-ambulatory) facility to serve up to 8 residents in the following client groups: emotionally disturbed/mental illness, advanced age, alcohol/drug dependent, physically disabled, traumatic brain injury, developmentally disabled, terminally ill, and irreversible dementia/Alzheimer's. On 01/29/2024, the facility's census was 8. On 01/29/2024, with information gathered through 02/22/2024, Surveyors conducted a verification visit, 2 complaint investigations, and a standard survey. As a result, 1 of 2 complaints were substantiated. Seven of 17 deficiencies were repeat citations with 10 new deficiencies identified. - 83.14(2)(a) Licensee Ensures Facility Complies with Laws - Repeat - 83.17(2)(a) Employees Screened for Communicable Disease - 83.35(3)(f) Staff Access to Assessment and ISP - 83.37(1)(g) Disposition of Medications - 83.37(3)(c) Medication Storage: Locked Cabinet - Repeat	{N 196}		

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{N 196}	Continued From page 2 - 83.38(1)(a) Personal Care - 83.41(1)(c) Dishwashing - 83.41(2)(a) Nutrition: Diet - 83.41(2)(c) Nutrition: Menus - 83.41(3)(b) Food Safety - Repeat - 83.43(1) Environment Safe, Clean, and Comfortable - Repeat - 83.45(3) Toxic Substances - Repeat - 83.47(2)(e) Other Evacuation Drills - 83.47(4)(a) Fire Extinguishers: Type and Inspection - Repeat - 83.55(3) Bath and Toilet Areas: Hand Drying - 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways - Repeat - 50.09(1)(f) Resident's Rights in Certain Facilities On 10/27/2023, the Department issued a Notice and Order letter with Statement of Deficiency (SOD) CUOK13, dated 05/23/2023. The letter stated: " . . . AS SOON AS PRACTICABLE AND WITHOUT DELAY, within 45 days of receipt of this notice, the licensee shall achieve and maintain substantial compliance with all requirements . . . " Special orders included: "Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS ... 1. Pursuant to Wis. Stat. § 50.03(5g)(b)6, the licensee shall develop and implement corrective measures to promote each resident's right to live in a safe, clean, comfortable and homelike environment. The licensee will IMMEDIATELY address potential health or safety hazards related to exit doors to ensure unobstructed travel to the outside.	{N 196}		

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{N 196}	Continued From page 3 WITHIN 45 DAYS, the licensee shall resolve each additional environmental issue identified in Statement of Deficiency (SOD) CUOK13. The licensee will provide training to all managers, and resident care staff on the corrective actions taken to resolve each environmental deficiency identified in SOD CUOK13. All training records will be maintained in personnel files and include the date/duration of training, the signature/qualifications of the instructor, and an outline of the course content ... 2. Pursuant to Wis. Admin. Code § DHS 88.03(6)(g)2.e., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and the case manager (if any) for each current resident with a copy of Statement of Deficiency (SOD) CUOK13 and a copy of this Notice and Order letter. The licensee shall retain evidence, acceptable to the Department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from the legal representative and case manager ..." On 01/29/2024, at 10:30 AM, Surveyors conducted an onsite verification visit of SOD CUOK13, 2 complaint investigations, and a standard survey. Surveyors conducted interviews with administration, caregivers, and residents, and made observations of the general environment and resident health and safety factors (unobstructed travel to the outside, food safety, and cleanliness). On 02/05/2024, at 11:55 AM, Surveyors requested evidence of special order 2 from Administrator A. Administrator A stated, "We did	{N 196}		

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{N 196}	Continued From page 4 not send them as I overlooked that portion. However, Community Care is aware of it as the Quality Provider department receives all SODs and discusses the issues with us when they receive them." On 02/22/2024, at 1:00 PM, Surveyors interviewed Licensee C and Administrator A. Licensee C and Administrator A confirmed they did not comply with the Notice and Order Letter. Administrator A confirmed a copy of the SOD and letter was not sent to Community Care, but Community Care contacted the provider to discuss it. They responded to Community Care as to their plan of correction.	{N 196}		
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 documentation was obtained from a registered nurse, physician,	N 220		

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N 220	Continued From page 5	N 220		

physician assistant, or clinical nurse practitioner indicating 3 of 3 employees reviewed were screened for communicable disease, including Tuberculosis (TB). Caregiver F's, Caregiver G's, and Caregiver H's records did not contain evidence of a communicable disease screening or a baseline TB test.

Findings include:

On 01/29/2024, at approximately 2:30 PM, Surveyors reviewed staff records and identified the following:

Caregiver F was hired on 10/19/2023. Caregiver F's record did not include evidence of a communicable health screen or baseline TB testing.

Caregiver G was hired on 12/20/2023. Caregiver G's record did not include evidence of a communicable health screen or baseline TB testing.

Caregiver H was hired on 09/14/2023. Caregiver H's record did not include evidence of a communicable health screen or baseline TB testing.

On 02/22/2024, at 1:00 PM, Surveyors interviewed Licensee C and Administrator A. They confirmed the code employees needed to be screened for communicable disease. Administrator A reported employees complete the form, go to the doctor, and the doctor would send the results to the provider. Administrator A reported s/he would send the TB testing for all employees to Surveyors by the end of the day.

As of 02/26/2024, at 9:00 AM, no further

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N 220	Continued From page 6 documentation was received.	N 220		
N 391	83.35(3)(f) Staff access to assessment and ISP Availability. All employees who provide resident care and services shall have continual access to the resident ' s assessment and individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all staff who provided resident care and services had continual access to assessments and individual service plans (ISPs) for the residents who resided in the community based residential facility (CBRF) at the time of the survey for 8 of 8 residents (Residents 2, 3, 6, 7, 8, 9, 10, and 11) reviewed. Findings include: On 01/29/2024, at approximately 11:30 AM Surveyors reviewed resident records located in the provider's electronic record keeping system with Caregiver F. The following was identified: Resident 2 was admitted on 12/27/2022, with diagnoses including vitamin d deficiency, hypertension, and muscle spasm of back. Resident 2's record did not contain an annual assessment or ISP. Resident 3 was admitted on 03/10/2023, with diagnoses including developmental disorder, depression, and alcohol abuse. Resident 3's record did not contain an annual assessment or ISP. Resident 6 was admitted on 12/06/2023, with	N 391		

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N 391	Continued From page 7	N 391		

diagnoses including adjustment disorder, suicidal ideations, type 1 diabetes, and heart failure. Resident 6's record did not contain an annual assessment or ISP.

Resident 7 was admitted on 07/23/2023, with a diagnosis of other cerebral infarction. Resident 7's record did not contain an annual assessment or ISP.

Resident 8 was admitted on 08/30/2023, with diagnoses including anoxic brain damage, heart failure, chronic kidney disease, psychoactive substance abuse, and agitation. Resident 8's record did not contain an annual assessment or ISP.

Resident 9 was admitted on 11/07/2023, with diagnoses including paranoid schizophrenia, bipolar disorder epilepsy, chronic pain syndrome, and post-traumatic stress disorder. Resident 9's record did not contain an annual assessment or ISP.

Resident 10 was admitted on 11/01/2023, with diagnoses including transient cerebral ischemic attack and alcohol dependence. Resident 10's record did not contain an annual assessment or ISP.

Resident 11 was admitted on 09/09/2023, with no diagnoses listed. Resident 11's record did not contain an annual assessment or ISP.

On 01/29/2024, at 11:45 AM, Surveyors interviewed Caregiver F. Caregiver F reported s/he did not know where the residents' ISPs or assessments were located. Caregiver F reported s/he worked in the facility previously, so s/he was aware of the residents' needs. Caregiver F

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N 391	Continued From page 8 reported the staff communicated with each other and the residents to ensure what needed to be completed. Surveyors inquired when residents received showers; Caregiver F reported no shower schedule was in place, so s/he was unaware of when residents required showers. On 01/29/2024, at 2:03 PM, Surveyors interviewed Resident 7. Resident 7 reported s/he required assistance with bathing. Resident 7 reported s/he required a shower 3 times per week, and s/he had not received a shower since November. On 02/22/2024, at 1:00 PM, Surveyors interviewed Licensee C and Administrator A. Administrator A confirmed the code requirement all employees who provide resident care and services should have continual access to the residents' assessment and individual service plan. Administrator A reported ISPs were maintained on the provider's electronic record keeping system. Administrator A reported each of their facilities also maintained a binder, accessible to staff, which had resident information and tasks. S/He stated residents had a shower schedule and if they wanted a shower outside of the schedule, the staff should have been accommodating it.	N 391		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written	N 406		

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N 406	Continued From page 9 every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on observation and interview, the provider did not establish an effective procedure for proper destruction and disposal of expired medications. Expired medications were observed stored with residents' non-expired medications for 1 of 8 residents (Resident 2). Resident prescription medications from previous months were located on a shelf in the medication closet, totaling 110 cards of prescription medications, for 8 of 8 residents (Resident 2, Resident 3, Resident 4, Resident 6, Resident 7, Resident 8, Resident 9, and Resident 10). Findings include: Example 1 On 01/29/2024, at 10:49 AM, Surveyors observed the medication closet. Surveyors observed the following expired medications:	N 406		

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N 406	Continued From page 10 Resident 2: Loperamide 2 milligrams (mg) capsule as needed (PRN); 15 capsules remaining, expired 12/14/2023 Buspirone 15 mg tablet, PRN; 29 tablets remaining, expired 12/18/2023 Antacid 500 mg chewable, PRN; 60 chewables remaining, expired 12/13/2023 Example 2 On 01/29/2024, at 10:49 AM, Surveyors observed a shelf inside the medication closet. Surveyors observed the following residents' previous months of medications located on the shelf: Resident 6: Aripiprazole tablet 5 mg, one tablet by mouth once daily; 26 tablets remaining Gabapentin capsule 300 mg, one capsule by mouth three times daily; 28 capsules (afternoon) Gabapentin capsule 300 mg, one capsule by mouth three times daily; 28 capsules (morning) Gabapentin capsule 300 mg, one capsule by mouth three times daily; 15 capsules (afternoon) Gabapentin capsule 300 mg, one capsule by mouth three times daily; 26 capsules (bedtime) Sevelamer tablet 800 mg, two tablets (1600 mg) by mouth three times daily; 26 capsules (evening) Resident 7: Carvedilol tablet 3.125 mg, one tablet by mouth twice a day; 24 tablets Carvedilol tablet 6.25 mg, one tablet by mouth twice a day; 15 tablets (4PM) Gabapentin capsule 100 mg, two capsules (200 mg) by mouth three times daily; 52 capsules (evening) Carvedilol tablet 3.125 mg, one tablet by mouth	N 406		

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twice a day; 6 tablets (evening)
Gabapentin capsule 300 mg, one capsule by mouth three times daily; 16 capsules (afternoon)
Vitamin D2 capsule 50000 international units (IU), one capsule by mouth every week on Wednesday; 1 capsule
Gabapentin capsule 100 mg, two capsules (200 mg) by mouth three times daily; 10 capsules (evening)
Eliquis tablet 5 mg, one tablet by mouth twice a day; 3 tablets (evening)
Gabapentin capsule 300 mg, one capsule by mouth three times daily; 3 capsules (morning)
Carvedilol tablet 6.25 mg, one tablet by mouth twice a day; 2 tablets (morning) baclofen tablet 5 mg, one tablet by mouth twice a day; 2 tablets (morning)
Levetiracetam tablet 1000 mg, one tablet by mouth twice a day for seizure prevention; 4 tablets (morning)

Resident 3:
Lisdexamfetamine dimesylate 70 mg capsule, one capsule by mouth every morning; 3 capsules
Certavite/antioxidant tablet, one tablet by mouth daily; 9 tablets
Lisdexamfetamine dimesylate 70 mg capsule, one capsule by mouth every morning; 4 capsules
Naltrexone tablet 50 mg, one tablet by mouth daily; 7 tablets
Zenpep capsule 25000 IU, one capsule by mouth three times a day with meals; 29 capsules (afternoon)
Pantoprazole tablet 40 mg, one tablet by mouth every evening before supper; 4 tablets
Zenpep capsule 25000 IU, one capsule by mouth three times a day with meals; 30 capsules (noon)
Quetiapine tablet 50 mg, one tablet by mouth every night at bedtime; 1 tablet
Gabapentin capsule 300 mg, two capsules (600

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N 406	Continued From page 12 mg) by mouth three times daily; 6 capsules (8 PM) Gabapentin capsule 300 mg, two capsules (600 mg) by mouth three times daily; 28 capsules (evening) Zenpep capsule 25000 IU, one capsule by mouth three times a day with meals; 8 capsules (evening) Gabapentin capsule 300 mg, two capsules (600 mg) by mouth three times daily; 52 capsules (noon) Zenpep capsule 25000 IU, one capsule by mouth three times a day with meals; 3 capsules (noon) Gabapentin capsule 300 mg, two capsules (600 mg) by mouth three times daily; 4 capsules (noon) Quetiapine tablet 50 mg, one tablet by mouth every night at bedtime; 11 tablets Gabapentin capsule 300 mg, two capsules (600 mg) by mouth three times daily; 12 capsules (morning) Folic acid tablet, one tablet by mouth daily; 7 tablets Zenpep capsule 25000 IU, one capsule by mouth three times a day with meals; 7 capsules (morning) Vitamin B1 100 mg tablet, two tablets (200 mg) by mouth daily; 14 tablets Fluoxetine capsule, one capsule by mouth daily; 8 capsules Pantoprazole tablet 40 mg, one tablet my mouth every evening before supper; 26 tablets Zenpep capsule 25000 IU, one capsule by mouth three times a day with meals; 26 capsules (4 PM) Gabapentin capsules 300 mg, two capsules (600 mg) by mouth three times daily; 4 capsules (8AM) Resident 8: Carvedilol tablet 3.125 mg, one tablet by mouth every 12 hours; 3 tablets (morning)	N 406		

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N 406	Continued From page 13 Carvedilol tablet 3.125 mg, one tablet by mouth twice a day; 1 tablet (4 PM) Midodrine 10 mg tablet, one tablet by mouth four times a day at 6AM, 10AM, 2PM, and 6PM; 2 tablets (6PM) Carvedilol tablet 3.125 mg, one tablet by mouth every 12 hours; 1 tablet (bedtime) Midodrine 10 mg tablet, one tablet by mouth four times a day at 6AM, 10AM, 2PM, and 6PM; 9 tablets (afternoon) Jardiance 10 mg tablet, one tablet by mouth daily; 3 tablets Furosemide 20 mg tablet, one tablet by mouth daily; 3 tablets Resident 9: Hydroxyzine hydrochloride (HCL) 50 mg tablet, one tablet by mouth three times daily; 1 tablet (2 PM) Clopidogrel 75 mg tablet, one tablet by mouth daily; 1 tablet Hydroxyzine hydrochloride (HCL) 50 mg tablet, one tablet by mouth twice daily; 3 tablets (evening) Lubiprostone capsule 24 micrograms (mcg), one capsule by mouth twice a day; 11 capsules Buspirone tablet 10 mg, one tablet by mouth twice daily; 2 tablets Aripiprazole tablet 5 mg, one tablet by mouth daily; 2 tablets Atorvastatin tablet 80 mg, one tablet by mouth daily; 1 tablet Lamotrigine tablet 100 mg, one tablet by mouth every 12 hours; 2 tablets (bedtime) Hydroxyzine hydrochloride (HCL) 50 mg tablet, one tablet by mouth three times daily; 3 tablets (bedtime) Gabapentin capsule 300 mg, four capsules (1200 mg) by mouth at bedtime; 4 capsules Cyclobenzaprine tablet 5 mg, one tablet by mouth	N 406		

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twice daily for muscle spasms until 09/24/2024; 26 tablets (morning)
Hydroxyzine hydrochloride (HCL) 50 mg tablet, one tablet by mouth three times daily; 1 tablet (afternoon)
Buspirone tablet 10 mg, one tablet by mouth twice daily; 1 tablet (morning)
Duloxetine HCL 60 mg, Two capsules (120 mg) by mouth once daily for depression; 2 capsules (morning)
Hydroxyzine hydrochloride (HCL) 50 mg tablet, one tablet by mouth three times daily; 3 tablets (morning)
Famotidine 20 mg tablet, one tablet by mouth once daily for GERD; 5 tablets (morning)
Lamotrigine tablet 100 mg, one tablet by mouth every 12 hours; 1 tablet (morning)
Clopidogrel 75 mg tablet, one tablet by mouth daily; 2 tablets (morning)
Lubiprostone capsule 24 mcg, one capsule by mouth twice a day; 5 capsules
Aripiprazole tablet 5 mg, one and a half tablets (7.5 mg) once daily; 4 doses remaining (6 tablets, 4 whole and 4 half)
Cyclobenzaprine tablet 5 mg, one tablet by mouth twice daily for muscle spasms until 09/24/2024; 8 tablets (morning)

Resident 2:
Sertraline HCL tablet, one tablet by mouth daily; 1 tablet
Bumetanide tablet 2 mg, one tablet by mouth daily; 2 tablets
Buspirone 10 mg tablet, one tablet by mouth twice a day; 1 tablet
Omeprazole capsule 20 mg, one capsule by mouth twice a day; 1 tablet
Vitamin D2 capsule 50000 IU, one capsule by mouth every week on Wednesday; 2 capsules
Bumetanide tablet 2 mg, one tablet by mouth

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daily; 5 tablets
Vitamin C tablet 500 mg, take 1 tablet by mouth daily; 1 tablet (morning 8AM)

Resident 10:
Hydroxyzine hydrochloride (HCL) 25 mg tablet, one tablet by mouth three times daily; 5 tablets (8 AM)
Famotidine 20 mg tablet, one tablet by mouth twice a day; 5 tablets (8 AM)
Methocarbam 500 mg tablet, ½ tablet (250 mg) by mouth three times a day; 5 (1/2) tablets (8 AM)
Ferrous gluconate 324 mg tablet, one tablet by mouth daily; 1 tablet
Vitamin B 100 mg tablet, one tablet by mouth daily; 5 tablets
Multivitamin tablet, one tablet by mouth daily; 1 tablet
Gabapentin capsule 300 mg, one capsule by mouth three times daily; 5 capsules (8 AM)
Aspirin low dose 81 mg tablet, chew one tablet by mouth daily; 5 tablets
Rifampin 300 mg capsule, two capsules (600 mg) by mouth daily; 2 capsules
Folic acid 1000 mcg tablet, 1 tablet daily; 5 tablets

Resident 4:
Tizanidine tablet 4 mg, one tablet by mouth twice daily; 31 tablets
Pregabalin capsule, one capsule by mouth three times daily; 31 capsules (afternoon)
Calcium/D3 tablet, one tablet by mouth twice daily; 29 tablets
Dantrolene 50 mg capsule, one capsule by mouth twice daily; 29 capsules (morning)
Duloxetine 60 mg capsule, one capsule by mouth daily; 29 capsules
Folic acid tablet 400 mcg, one tablet by mouth daily; 29 tablets
Furosemide tablet 20 mg, ½ tablet (10 mg) by

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mouth daily; 29 (1/2) tablets
Levetiracetam tablet 250 mg, one tablet by mouth twice daily; 29 tablets
Losartan tablet 25 mg, ½ tablet (12.5 mg) by mouth daily; 29 (1/2) tablets
Metoprolol extended release (ER) tablet 25 mg, one tablet by mouth daily; 29 tablets
Pregabalin capsule, one capsule by mouth three times daily; 29 capsules
Folic acid tablet 400 mcg, one tablet by mouth daily; 24 tablets (morning)
Vitamin B1 100 mg tablet, take one tablet by mouth daily; 29 tablets (morning)
Vitamin B12 500 mcg tablet, take one tablet by mouth daily; 29 tablets (morning)
Xarelto 20 mg tablet; 29 tablets (morning)
Tizanidine tablet 4 mg, one tablet by mouth twice daily; 28 tablets (morning)
Acetaminophen 500 mg tablet, two tablets by mouth twice daily; 58 tablets (29 doses) (morning)
Aspirin 81 mg tablet, one tablet by mouth daily; 29 tablets (morning)
Nortriptyline 10 mg capsule, 2 tablets by mouth every night at bedtime; 62 tablets (bedtime)
Pregabalin capsule, one capsule by mouth three times daily; 31 capsules (bedtime)
Levetiracetam tablet 250 mg, one tablet by mouth twice daily; 31 tablets (bedtime)
Dantrolene 50 mg capsule, one capsule by mouth twice daily; 31 capsules (bedtime)
Calcium/D3 tablet, one tablet by mouth twice daily; 31 tablets (bedtime)
Acetaminophen 500 mg tablet, two tablets by mouth twice daily; 62 tablets (bedtime)

On 02/22/2024, at 1:00 PM, Surveyors interviewed Licensee C and Administrator A. Administrator A confirmed the code requirement. Administrator A reported an employee was

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N 406	Continued From page 17 assigned to this task, but s/he no longer worked at the facility. Administrator A had been completing this task, and stated, "I have no explanation." Administrator A stated, " ...I should be coming to pick them up and disposing of them." Licensee C stated, "the bottom line is old medications and not received medications need to be out of the house."	N 406		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure residents' medications were securely stored in the medication closet. The medication closet was unsecured, and a bin of medications was stored in the entryway for 4 days. This had the potential to affect 8 of 8 residents. This is a repeat deficiency. See Statement of Deficiency (SOD) CUOK12, dated 05/10/2022. Findings include: On 01/29/2024, at 10:30 AM, Surveyors toured the facility and observed the following: -A blue plastic bin with interlocking cover located in the front entryway of the facility. The bin did not have a locking mechanism. -An unsecured door labeled, "employees only." The door had a key code locking mechanism which was not engaged. The room contained a	N 419		

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medication refrigerator, and an open shelving unit. The refrigerator and the open shelving contained prescription medications. The medication refrigerator did not contain a locking mechanism.

At approximately 11:30 AM, Caregiver F brought a blue bin into the medication room. Caregiver F confirmed this was the same bin located by surveyors in the front entryway.

Surveyors observed the following prescription cycle medications for 2 of 8 residents, located in the bin:

Resident 9: aspirin low dose 81 milligrams (mg), atorvastatin 80 mg, buspirone 10 mg, clopidogrel 75 mg, duloxetine 60 mg, famotidine 20 mg, gabapentin 300 mg, hydroxyzine hydrochloride (HCL) 50 mg, lamotrigine 100 mg, lubiprostone 24 mcg, melatonin 3 mg, vitamin D2 (ergocalciferol) 50,000 international units (IU)/1.25 mg, lacosamide 200 mg

Resident 2: aripiprazole 30 mg, bumetanide 2 mg, buspirone 10 mg, meloxicam 15 mg, metoprolol succinate 50 mg, montelukast 10 mg, omeprazole 20 mg, potassium chloride 10 milliequivalent (mEq), sertraline 50 mg, spironolactone 50 mg, trazodone 50 mg, vitamin D2 (ergocalciferol) 50,000 IU/1.25 mg, vitamin C 500 mg, zinc gluconate 50 mg.

Surveyors observed residents moving freely throughout the facility during the entire duration of the on-site survey, from approximately 10:30 AM - 3:00 PM.

On 01/29/2024, at 10:56 AM, Surveyors interviewed Caregiver F. Surveyors inquired why

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the medication door was unsecured. Caregiver F stated, "I don't have the code." S/He reported s/he left the door to the medication closet unlocked so s/he could access the room. Surveyors inquired how Caregiver F got the door open if s/he did not have the code. Caregiver F reported s/he had the shift prior to her/him open the door before they left. Caregiver F confirmed the bin was the same bin which was located on the floor near the front door of the facility. S/He was unaware of when the bin of medications was delivered by the pharmacy, or how long the medications had been sitting there unsecured. Surveyors observed Caregiver F inventorying the contents of the bin and securing them in the medication cart. Caregiver F confirmed the bin contained all residents' whole cycle of medications.

On 01/29/2024, at 12:45 PM, Surveyors interviewed Administrator A. Administrator A reported the code to the medication closet was the same as another code they used; therefore, it should have been known to the caregivers. Administrator A reported the bin of medications Caregiver F located at the entryway was not there when s/he stopped in on Sunday, 01/28/2024, at approximately 6:00 PM.

On 01/30/2024, at 10:47 AM, Administrator A sent Surveyors an email stating, "While looking at the med (medication) manifest, I noticed that [Caregiver F] . . . signed for the meds on the 25th. I went back and reviewed the front door security camera and saw they were delivered at 3 pm [sic] on that day. But I do not see [her/him] on camera bringing them into the medication room at or around that time . . . "

On 01/30/2024, at 10:50 AM, Surveyors reviewed

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the pharmacy delivery manifest. The pharmacy delivery manifest reported the bin of medications was delivered on 01/25/2024, and signed for by Caregiver F. The delivery manifest reported the bin contained 71 total prescriptions, for 8 residents.

On 01/31/2024, at 1:00 PM, Surveyors reviewed resident's Individual Service Plan (ISP) and identified the following:

-Resident 2's ISP, dated 01/15/2023, stated, "Resident is unable to manage own medication . . . Staff administer all medication prescribed to him/her as scheduled and PRN (as needed) . . . Medications are locked up in the medication cart and resident is unable to access the medications without staff . . . "

-Resident 3's ISP, dated 04/16/2023, stated "Resident is unable to manage own medication . . . Staff administer all medication prescribed to him/her as scheduled and PRN . . . Medications are locked up in the medication cart and resident is unable to access the medications without staff . . . "

-Resident 6's ISP, dated 01/04/2024, stated, "Resident is unable to manage own medication . . . Staff administer all medication prescribed to him/her as scheduled and PRN . . . Medications are locked up in the medication cart and resident is unable to access the medications without staff . . . "

-Resident 7's ISP, dated 08/01/2023, stated, "Resident is unable to manage own medication . . . Staff administer all medication prescribed to him/her as scheduled and PRN . . . Medications are locked up in the medication cart and resident

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N 419	Continued From page 21 is unable to access the medications without staff . . . " -Resident 8's ISP, dated 09/21/2023, stated, "Resident is unable to manage own medication . . . Staff administer all medication prescribed to him/her as scheduled and PRN . . . Medications are locked up in the medication cart and resident is unable to access the medications without staff . . . Daily [s/he] goes to a methadone clinic due to past addiction issues." -Resident 9's ISP, dated 12/09/2023, stated, "Resident is unable to manage own medication . . . Staff administer all medication prescribed to him/her as scheduled and PRN. . . Medications are locked up in the medication cart and resident is unable to access the medications without staff." On 02/22/2024, at 1:00 PM, Surveyors interviewed Licensee C and Administrator A. They confirmed the medications should have been locked. Administrator A stated the codes for locks and other information had been in the facility's binder, which was accessible to staff.	N 419		
N 425	83.38(1)(a) Personal care. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Personal care.	N 425		

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N 425	Continued From page 22 Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure personal care services were designed and provided to allow residents to increase or maintain independence for 1 of 8 residents (Resident 7). Resident 7 did not receive showers as scheduled. Findings include: On 01/29/2024, at 2:03 PM, Surveyors interviewed Resident 7. Resident 7 reported s/he had not had a shower since November 2023. Resident 7 reported s/he needed help getting into the shower, as well as getting into bed. Resident 7 reported 1 caregiver would help her/him into bed by lifting her/him by her/his arm. Resident 7 reported s/he needed the same assistance with the shower, but staff reported Resident 7 required 2 staff to assist her/him in the shower. Resident 7 reported there was only one staff on a shift, so s/he did not get a shower. On 01/29/2024, at approximately 2:10 PM, Surveyors interviewed Caregiver F. Caregiver F reported there was no shower schedule indicating what days the residents' received showers. Caregiver F reported Resident 7 did not get a shower due to "staff on 2nd shift will not give her/him one because there is not a second staff." Caregiver F reported s/he was unsure why Resident 7 required a second staff member to	N 425		

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N 425	Continued From page 23 assist with the shower. On 01/31/2024, at approximately 1:00 PM, Surveyors reviewed Resident 7's care plan, dated 08/01/2023. Resident 7's care plan stated the following: "Bathing/Showering - Total Assistance ... Provide full assistance bathing/showering. Assist with dressing and undressing, wash, shampoo and with all required physical assistance on scheduled shower days and PRN (as needed). Schedule: Weekly [Mon, Wed, Fri] @ 10:00 AM . . . Service Provider Responsibilities: Staff" "Transferring - Full assistance . . . Needs full assistance with all transferring needs . . . requires full assistance including moving from bed to wheelchair/device to open areas of facility/Service Provider Responsibilities: Staff." On 02/22/2024, at 1:00 PM, Surveyors interviewed Administrator A. Administrator A reported a shower schedule was in place for all residents. Administrator A reported Resident 7 refused showers and had some inappropriate behaviors which caused the staff to be uncomfortable giving Resident 7 a shower. Administrator A reported if staff were uncomfortable, staff should have been assisting Resident 7 with a shower during cross shifts when there were 2 staff available. Administrator A stated s/he would have staff document behaviors and refusals.	N 425		
N 447	83.41(1)(c) Dishwashing Dishwashing. 1. Whether washed by hand or mechanical means, all equipment and utensils	N 447		

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shall be cleaned using separate steps for pre-washing, washing, rinsing and sanitizing. Residential dishwashers may be used in kitchens serving 20 or fewer residents. Kitchens serving 21 or more residents shall have a commercial type dishwasher for washing and sanitizing equipment and utensils in accordance with standard practices described in the Wisconsin food code. 2. A 3-compartment sink for washing, rinsing and sanitizing utensils, with drain boards at each end is required for all large facilities with a central kitchen. Washing, rinsing and sanitizing procedures shall be in accordance with standard practices described in the Wisconsin food code. In addition, a single compartment sink or overhead spray wash located adjacent to the soiled drain board is required for pre-washing.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure all equipment and utensils were cleaned using separate steps for pre-washing, washing, rinsing, and sanitizing. This had the potential to affect 8 of 8 residents.

Findings include:

On 01/29/2024, at 12:02 PM, Surveyor observed Caregiver F washing dishes by hand in a 2-compartment sink. Surveyors observed Caregiver F place soap on a washcloth, run the washcloth under running water, wash the dishes, rinse the dishes under running water and place the dishes in a strainer. Surveyors did not observe Caregiver F complete a sanitation of the dishes.

On 01/29/2024, at 12:10 PM, Surveyors

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N 447	Continued From page 25 interviewed Caregiver F. Caregiver F reported the dishwasher was not working. Caregiver F reported the process for washing dishes was to use soap, hot water, to rinse the dishes, and to allow the dishes to air dry. Caregiver F reported s/he was unaware the dishes required sanitizing after the rinse cycle. On 01/29/2024, at approximately 12:45 PM, Surveyors interviewed Administrator A. Administrator A confirmed dishes were to be sanitized after the rinse cycle. Administrator A reported the dishwasher was to be fixed, but due to the weather, the repair company had to cancel the service appointment. Administrator A reported the repair was rescheduled for 01/19/2024 but the technician did not show up. Administrator A reported s/he would talk with Licensee C regarding the dishwasher.	N 447		
N 448	83.41(2)(a) Nutrition: diet. Diets. 1. The CBRF shall provide each resident with palatable food that meets the recommended dietary allowance based on current dietary guidelines for Americans and any special dietary needs of each resident. 2. The CBRF shall provide a therapeutic diet as ordered by a resident ' s physician. This Rule is not met as evidenced by: Based on observation, record review, and interview the provider did not ensure 8 of 8 residents were provided with palatable food which met the recommended dietary allowance based on current dietary guidelines for Americans and	N 448		

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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 448	Continued From page 26	N 448		

any special dietary needs of each resident. The provider did not ensure the low sodium diet needs of Resident 2 and Resident 11 were provided. The provider did not ensure the diabetic diet needs of Resident 6 were provided.

Findings include:

The provider is licensed to serve up to 8 residents in the following client groups: emotionally disturbed/mental illness, advanced age, alcohol/drug dependent, physically disabled, traumatic brain injury, developmentally disabled, terminally ill, and irreversible dementia/Alzheimer's.

On 10/18/2023, the department received a complaint regarding food in the facility was inadequate.

On 01/29/2024, at 12:00 PM, Surveyors toured the kitchen in the facility. Surveyors observed Caregiver F baking 2 containers of a pre-packaged frozen meal for lunch which appeared to consist of pasta, chicken, and broccoli in a cheese type sauce. Resident 10 was observed asking Caregiver F for juice. Caregiver F stated the only thing the facility had to drink was water. Surveyors observed a gallon and a half of milk in the refrigerator. Surveyors observed multiple black type containers of frozen meals in the freezers. All the frozen meals were missing the box sleeve label, which identified what the meal was, nutrition facts, and how to cook the meal.

On 01/29/2024, at 1:47 PM, Surveyors interviewed Resident 2. Resident 2 reported the facility did not have food. S/He stated, "For 5 days straight we ate sausage and pancakes for

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N 448	Continued From page 27 breakfast." On 01/29/2024, at 1:45 PM, Surveyors interviewed Resident 6 and Resident 11. Resident 6 reported s/he was a diabetic. Resident 11 reported s/he was on a low sodium diet because s/he goes to dialysis. When Surveyors inquired if there was enough food in the facility, Resident 11 stated, "[Expletive] to the no, there is not a variety." Resident 6 reported there was not enough food in the facility. Resident 6 and Resident 11 reported when there was food in the facility, the staff do not cook. Resident 11 stated, "The food is all frozen dinners, no one actually cooks, I would like food from my ethnic background." When Surveyors inquired if there were accommodations for special diets, Resident 6 stated, "I watch that myself with the extra snacks and stuff." Resident 11 reported s/he had never had a special meal made to accommodate her/his low sodium diet. On 01/312024, at 2:00 PM, Surveyors reviewed resident Individual Service Plans (ISPs) and identified the following: - Resident 2 was admitted on 12/27/2022, with diagnoses including hypertension. Resident 2's ISP indicated Resident 2 was prescribed a low sodium diet. - Resident 6 was admitted on 12/06/2023, with diagnoses including type 1 diabetes and heart failure. Resident 6's ISP indicated Resident 6 was prescribed a low sodium diet. -Resident 11 was admitted on 09/09/2023, with unknown diagnoses. Resident 11's ISP was not sent to Surveyors.	N 448		

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N 448	Continued From page 28 "A main source of sodium is table salt. The average American eats five or more teaspoons of salt each day. This is about 20 times as much as the body needs. In fact, your body needs only 1/4 teaspoon of salt every day. Sodium is found naturally in foods, but a lot of it is added during processing and preparation. Many foods that do not taste salty may still be high in sodium. Large amounts of sodium can be hidden in canned, processed and convenience foods. And sodium can be found in many foods that are served at fast food restaurants. Sodium controls fluid balance in our bodies and maintains blood volume and blood pressure. Eating too much sodium may raise blood pressure and cause fluid retention, which could lead to swelling of the legs and feet or other health issues. When limiting sodium in your diet, a common target is to eat less than 2,000 milligrams of sodium per day." (Source: University of California San Francisco, Guidelines for a Low Sodium Diet, https://www.ucsfhealth.org/education/guidelines-for-a-low-sodium-diet (retrieval date - February 29, 2024).) "Carbohydrate consistent diet is another way to say a diabetic or carb counting diet. Carbs in food make your blood sugar levels go higher after you eat them than when you eat proteins or fats. You can still eat carbs if you have diabetes. The amount you can have and stay in your target blood sugar range depends on your age, weight, activity level, and other factors. Counting carbs in foods and drinks is an important tool for managing blood sugar levels." (Source: Centers for Disease Control and Prevention, Manage Blood Sugar, September 30, 2022, https://www.cdc.gov/diabetes/managing/manage-blood-sugar.html (retrieval date - February 29, 2024).)	N 448		

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N 448	Continued From page 29 On 02/22/2024, at 1:00 PM, Surveyors interviewed Licensee C and Administrator A. Administrator A reported s/he was responsible for grocery shopping. S/He needed to update their menus. Administrator A was aware of 1 resident requiring a low sodium diet. Administrator A confirmed the meals offered to residents needed to be more tailored. Administrator A reported the brand of frozen dinners Surveyors observed in the freezer were Stouffer's frozen meals. On 02/22/2024, at 3:00 PM, Surveyors reviewed nutritional facts for Stouffer's cheesy chicken & broccoli pasta bake. The sodium level in a 1 cup serving is 850 milligrams (mg) and 37% of the daily value. "Know the Daily Value. The Daily Values are reference amounts of nutrients to consume or not to exceed each day. The Daily Value for sodium is less than 2,300 milligrams (mg) per day. Use % Daily Value (%DV) as a tool. The %DV is the percentage of the Daily Value for each nutrient in a serving of the food and shows how much of a nutrient contributes to a total daily diet. Use %DV to determine if a serving of the food is high or low in sodium and to compare and choose foods to get less than 100% DV of sodium each day. As a general guide: 5% DV or less of sodium per serving is considered low, and 20% DV or more of sodium per serving is considered high. Pay attention to servings. The nutrition information listed on the Nutrition Facts label is usually based on one serving of the food. Check the serving size and the number of servings you eat or drink to determine how much sodium you are consuming." (Source: Food and Drug Administration, Sodium in Your Diet, https://www.fda.gov/food/nutrition-education-reso	N 448		

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N 448	Continued From page 30 urces-materials/sodium-your-diet (retrieval date - February 29, 2024).)	N 448		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not make menus available to 8 of 8 residents. Findings include: On 01/29/2024, at 12:11 PM, Surveyors observed a dry erase board on the kitchen counter. The board stated, "Today is January 2 [blank]; Breakfast: [blank]; Lunch: staff choice; Snack: cakes; Dinner: [blank]; Snack: resident choice." On 01/29/2024, at 12:15 PM, Surveyors reviewed a binder titled, "Menus." Surveyors did not observe menus in the binder. At approximately 12:10 PM, Surveyors interviewed Caregiver F. Caregiver F reported there was no menu. Caregiver F reported 3rd shift was supposed to make the menu but often did not. Caregiver F reported s/he prepared what food s/he could find. On 02/22/2024, at 1:00 PM, Surveyors	N 450		

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N 450	Continued From page 31 interviewed Administrator A. Administrator A confirmed they were required to provide a menu to residents. Administrator A reported the facility kept a binder of menus and rotated it every 6-8 weeks. S/He stated, "I can't remember the last time I looked at that binder."	N 450		
{N 452}	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored and served under sanitary conditions for the prevention of food borne illnesses, which had the potential to affect 8 of 8 residents residing in the facility. A package of ground beef was thawing at room temperature on the kitchen counter for approximately 1.5 hours. Food was found in the refrigerator, freezer,	{N 452}		

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{N 452}	Continued From page 32	{N 452}		

cabinets/drawers, and on the kitchen counter tops unlabeled and/or unsealed. Food items requiring refrigeration were stored in drawers and on the countertop.

This deficiency is being cited for a fourth time. See Statements of Deficiency (SOD) CUOK11, dated 09/20/2021, SOD CUOK12, dated 05/10/2022, and SOD CUOK13, dated 05/23/2023.

Findings include:

On 01/29/2024, between 10:30 AM and 12:05 PM, Surveyors observed a package of ground beef thawing on the kitchen counter. At 12:05 PM, Surveyors took the temperature of the ground beef; the thermometer read 62.8 degrees Fahrenheit.

According to the SERVSAFE 7th Edition Coursebook ©2017 National Restaurant Association Educational Foundation chapter 8, page 3 refers to thawing frozen food and states, "When frozen food is thawed and exposed to the temperature danger zone, pathogens in the food will begin to grow. To reduce this growth, NEVER thaw food at room temperature." (SERVSAFE Course Book, 7th Ed., 2017, ch.8 p.3)

On 01/29/2024, at 12:00 PM, Surveyors toured the kitchen and observed the following:

Inside the kitchen cabinet drawer and on the countertop were:

-1 package of Azteca flour tortillas, in a bin on the counter, labeled "12-29" and "keep refrigerated." The tortillas contained green dots ranging from pinpoint to pea-size, which appeared to be mold.

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{N 452}	Continued From page 33 - 3 packages of Azteca flour tortillas, in a kitchen drawer, labeled "keep refrigerated." The following were open and unlabeled items found in the kitchen refrigerator: -1 package of cooked ham -1 package of smoked ham -1 package of Oscar Mayer original uncooked bacon (unsealed) -1 package of sharp cheddar cheese (unsealed) -1 stick of summer sausage (unsealed) -1 package of English muffins -1 container of cool whip -1 container of sour cream -1 container of Imperial vegetable oil spread -1 package of imitation bacon bits -2 bottles of creamy French dressing -1 bottle of ketchup -2 bottles of yellow mustard -1 jar of pickle relish -1 jar of taco sauce -1 jar of kosher dill spears The following were open and unlabeled items found in the kitchen freezer: -1 container of chocolate ice cream -1 container of homemade vanilla ice cream -3 packages of brown patties, which appeared to be burgers (unsealed) The following were open and unlabeled items found in the kitchen cabinets/drawers: -1 bag of white rice (unsealed) -1 container of Folgers ground coffee -1 container of creamy peanut butter -1 container of McCormick Bac'n pieces -2 bottles of Country Kitchen maple syrup	{N 452}		

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{N 452}	Continued From page 34 -1 container of hazelnut powdered creamer (unsealed) -1 package of wheat snack crackers (unsealed) -1 container of chocolate fudge frosting -1 container of cream cheese frosting -1 bag of oyster crackers (unsealed) -1 bag of Starbucks green apron blend whole bean coffee beans -5 loaves of Butternut white bread -2 packages of hot dog buns -1 package of hamburger buns According to the Wisconsin Food Code, the Federal Department of Agriculture's Food Code, and ServSafe standards, date marking is necessary to indicate when food must be consumed or discarded. These standards indicate refrigerated, read to eat (RTE), potentially hazardous food (PHF), and time/temperature controlled for safety (TCS) foods that are removed from manufacturer packaging and/or prepared for consumption must be date marked and discarded within 7 days. Refrigerated, RTE, PHF, and TCS foods prepared and packaged in a food processing plant shall also be date-marked when opened in the facility (date not to exceed 7 days). (ServSafe Coursebook, 7th Ed., 2017, p. 5-23) On 01/29/2024, at 12:45 PM, Surveyors interviewed Administrator A. Administrator A reported residents had been known to open food and put it back in the kitchen without properly labeling, sealing, and/or storing it. S/He reported staff were responsible for cleaning and maintaining the storage areas for food. Administrator A stated, "If they see bad food when they open the fridge they should be throwing it away."	{N 452}		

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{N 481}	Continued From page 35	{N 481}		
{N 481}	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interviews, the provider did not ensure the living environment was safe, clean, comfortable, and homelike. This deficiency is being cited for the fourth time. See Statements of Deficiency (SOD) CUOK11, dated 09/20/2021, SOD CUOK12, dated 05/10/2022, and SOD CUOK13, dated 05/23/2023. Findings include: On 01/29/2024, at 10:30 AM, Surveyors toured the facility and observed the following: Hallways - The southwest entry windowsill contained numerous bug carcasses, cobwebs, and approximately 1/8 inch of a grayish substance, consistent with dust and debris. - The northeast hallway floor was covered in debris, wrappers, and other garbage-like material. Sunroom - The sunroom contained 2 individual chairs, one of which was broken and leaning on one corner of the frame.	{N 481}		

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{N 481}	Continued From page 36 - The wall behind the 2 chairs was scuffed in several areas; the scuffs were dark brown in color approximately 9 feet in length. - The walls contained 6 gouges of drywall missing, approximately ¾ inch in length or more. Some of the gouges appeared to be painted over while other gouges showed the white drywall underneath the paint. - The tv stand had glass doors and a wood frame. The glass was not clear and from top to bottom it was splattered and streaked with a white/gray substance. The wood frame was covered in approximately ¼ inch of a grayish substance, consistent with dust and debris. Bathrooms Southeast Resident Bathroom - The cabinet had black/gray scuff marks which stretched across approximately 24 inches, the entire width of the cabinet, and approximately 12 inches up from the floor. - The paint on the walls was chipped in many spots, showing the white of the base/drywall. - The bracket for the toilet paper holder was attached to the wall, but the toilet paper holder was not attached and hanging on the grab bar without toilet paper. - No paper towels for hand drying Southwest Resident Bathroom - The baseboards were covered in approximately 1/8 inch of a grayish substance, consistent with dust and debris. - The paint on the walls was chipped in many spots, showing the white of the base/drywall. - The bracket for the toilet paper holder was attached to the wall, but there was not a toilet paper holder. A roll of toilet paper was on top of the toilet tank. - No paper towels for hand drying	{N 481}		

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{N 481}	Continued From page 37 East Resident Bathroom - The grab bar was missing screws and was not secured to wall. - The paint on the walls was chipped in many spots, showing the white of the base/drywall. - The bracket for the toilet paper holder was attached to the wall, but there was not a toilet paper holder. - The ceiling vent fan was covered in approximately ¼ inch of a grayish substance, consistent with dust and debris. - The ceiling over the shower had brownish smear marks approximately 18 inches in length, consistent with feces or dried blood. - The wall behind the toilet had 3 holes, approximately ¼ inch in diameter, beneath the return air vent. - No paper towels for hand drying Kitchen - A large pot filled with a reddish/brown liquid was on the stove. The liquid inside appeared to be settled, as it was separated with oil-like liquid on top and sediments on the bottom. - A bin on the counter was filled with packaged food items, and the inside of the bin was covered in a white powdery substance, consistent with the pudding packets stored inside, and other debris. - The coffee pot was covered in brown stains, and dark brownish matter was splashed and dried on the backsplash. - The cabinet drawers, which contained bread items and onions, were covered in a yellowish dried sticky substance which was able to be scratched off by Surveyors fingernails. - The cabinet faces were streaked and spotted with an oil-like substance. - The wall next to the refrigerator had a brownish/gray dried liquid splashed in many	{N 481}		

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{N 481}	Continued From page 38	{N 481}		

places, measuring the entire height of the refrigerator.
- The floor had many areas with blackish/gray marks, consistent with dried spilled food and liquids.
- The inner frame of the microwave was rusted and chipped.
- Inside the oven was a dried brownish greasy substance, consistent with grease and food debris

Dining Room
- There was a crack (53 inches in length) on a support beam, with paint chipping and hanging loose.
- The dining table and chairs did not have adequate seating for all 8 residents to dine together.

Resident 7's Room
- The top 2 dresser drawers were broken away from the sliding brackets and lying on top of the lower 2 drawers. The top drawer was missing the side boards, and screws were protruding from the back of the attached face of the drawer.
- The bed had a waterproof mattress cover and a fitted sheet but was missing a mattress pad.

Community Area
- Two of 2 couches were covered with sheets.

Basement
- The chest freezer had a black spotted substance around the inside of the seal, consistent with mold.

Overall facility
-Sticky trap fly ribbons were attached to the ceiling/walls in common areas of the facility, including the kitchen above the sink and the

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{N 481}	Continued From page 39 dining room. - The facility's hallway walls were scuffed in numerous places, and several spots had dried splatter marks. - Cob webs were observed in many corners of ceilings throughout the facility. On 01/29/2024, at 12:45 PM, Surveyors interviewed Administrator A. Administrator A reported s/he had told Licensee C the walls in the facility needed protective wall guards. On 02/22/2024, at 1:00 PM, Surveyors interviewed Licensee C and Administrator A. Licensee C was responsible for the maintenance of the facility and had utilized a subcontractor when she/he could not complete the maintenance. Administrator A reported staff had cleaning schedules and should have completed the tasks during their shifts. Staff were responsible for keeping paper towels and other items stocked within the facility.	{N 481}		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were securely stored in 6 of 6 resident areas. Cleaning compounds were not securely stored in the medication closet, southeast resident bathroom, laundry room, kitchen, and the east resident bathroom.	N 499		

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N 499	Continued From page 40 This is a repeat deficiency. See Statement of Deficiency (SOD) CUOK11, dated 09/20/2021. Findings include: The provider is licensed to serve up to 8 residents in the following client groups: emotionally disturbed/mental illness, advanced age, alcohol/drug dependent, physically disabled, traumatic brain injury, developmentally disabled, terminally ill, and irreversible dementia/Alzheimer's. The census at the time of survey was 8. On Monday, 01/29/2024, at 10:30 AM, Surveyors toured the facility and observed the following: Medication Closet: The medication closet was unsecured and contained a locking mechanism which was not engaged. The closet contained 2 bottles of isopropyl alcohol and 1 bottle of OdoBan disinfectant. Southeast Resident Bathroom: The bathroom sink cabinet was unsecured and did not contain a locking mechanism. The bathroom contained 1 bottle of Drano clog remover. Laundry Room: The laundry room was unsecured and contained a locking mechanism which was not engaged and not in working order. The laundry room contained 1 bottle of Windex cleaner, 1 bottle of Fabuloso multi-purpose cleaner, 1 bottle of Clorox cleaner + bleach, 1 bottle of Clorox disinfecting bleach, 2 bottles of OdoBan disinfectant, and 1 container of Wind Fresh laundry detergent.	N 499		

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N 499	Continued From page 41 Kitchen: The kitchen cabinet beneath the sink was unsecured and did not contain a locking mechanism. The cabinet contained 1 tub of dishwasher packs, 1 bottle of Clorox bleach, 1 bottle of OdoBan disinfectant, 1 bottle of Pine-Sol multi-surface cleaner, 1 uncapped bottle of oven, grill and fryer cleaner, 1 clear bottle labeled Pine-Sol which contained a clear liquid, and 1 clear unlabeled bottle which contained a yellow liquid. A sign was posted on the front of the cabinet which stated, "Do not put chemicals under sink! All chemicals are to be locked up in the laundry room closet!" East Resident Bathroom: The bathroom sink cabinet was unsecured and did not contain a locking mechanism. The bathroom contained 2 bottles of Lysol toilet bowl cleaner. Surveyors observed residents moving freely throughout the facility. On 01/29/2024, at 12:45 PM, Surveyors interviewed Administrator A. Administrator A confirmed cleaning supplies were to be secured. Administrator A reported a sign was placed on the front of the kitchen cabinet to ensure staff locked cleaning compounds and toxic substances in the laundry room. Administrator A reported the lock to the laundry room door was not in working order. On 02/22/2024, at 1:00 PM, Surveyors interviewed Licensee C and Administrator A. Administrator A reported a new key code lock would be installed on the laundry room door and staff would be directed to lock all cleaning compounds and toxic substances in the laundry	N 499		

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N 499	Continued From page 42 room.	N 499		
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 evacuation drills were conducted at least semi-annually for 2 of 2 years. No documentation was provided for other evacuation drills for 2022 and 2023. Findings include: On 01/29/2024, Surveyors requested documentation other evacuation drills from Administrator A. No documentation of other evacuation drills was received. On 02/22/2024, at 1:00 PM, Surveyors interviewed Administrator A. Administrator A reported other evacuation drills should have been completed once a year. S/He reported the other drills were kept in the same binder as the fire drills. S/He reported s/he would send documentation of other drills for 2022 and 2023 by the end of the day. As of 02/26/2024, at 9:00 AM, no further documentation was received.	N 526		
N 531	83.47(4)(a) Fire extinguishers: type and inspection. At least one portable dry chemical fire	N 531		

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N 531	Continued From page 43	N 531		

extinguisher with a minimum 2A, 10-B-C rating shall be provided on each floor of the CBRF. All fire extinguishers shall be maintained in readily usable condition. Inspections of the fire extinguisher shall be done by a qualified professional one year after initial purchase and annually thereafter. Each fire extinguisher shall be provided with a tag documenting the date of inspection.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure 3 of 8 fire extinguishers observed were maintained in readily usable condition. The fire extinguishers in the facility did not have tags indicating the month and year the fire extinguisher was last inspected.

This is a repeat deficiency. See Statement of Deficiency (SOD) YGSU11, dated 12/08/2022.

Findings include:

On 01/29/2024, at 10:40 AM, Surveyors toured the facility and observed the following:

-The fire extinguisher in the front entry of the facility did not contain a tag.

-The fire extinguishers in the northeast hallway had a tag indicating the last inspection was 04/2022.

-The fire extinguisher in the kitchen had a tag indicating the last inspection was 04/2022.

On 01/29/2024, at 12:45 PM, Surveyors interviewed Administrator A. Administrator A confirmed all 8 fire extinguishers in the facility were not tagged with the date of inspection or

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N 531	Continued From page 44 were tagged with the expired date of 04/2022. Administrator A reported Licensee C had the tags for the fire extinguishers, but they were not at the facility. Administrator A confirmed the fire extinguishers should have had tags with the date of inspection. S/He stated, "I was unaware the tags needed to be on the fire extinguishers. I just thought that we needed to have them available to show they were inspected." On 02/22/2024, at 1:00 PM, Surveyors interviewed Licensee C. Licensee C stated s/he was having problems with residents tearing off the tags, and s/he was informed by the fire marshal the tags could have been kept in a binder off site. Licensee C reported s/he would ensure the tags were attached to the fire extinguishers in the future.	N 531		
N 612	83.55(3) Bath and toilet areas: hand drying. Hand drying. All sink areas shall have dispensers for single use paper towels, cloth towel dispensing units that are enclosed for protection against being soiled or electric hand dryers. This requirement does not apply to sink areas located in toilet rooms accessed directly from a resident bedroom. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all sink areas had functioning dispensers for single use paper towels. Three of 3 resident bathrooms' paper towel dispensers were empty, and no other means were provided to conduct hand drying. Findings include:	N 612		

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N 612	Continued From page 45 On 01/29/2024, at 10:30 AM, Surveyors toured the facility and observed no paper towels in 3 of 3 bathrooms used by residents and staff. On 02/22/2024, at 1:00 PM, Surveyors interviewed Licensee C and Administrator A. They confirmed all sink areas should have had dispensers for single use paper towels. Administrator A reported staff were responsible for keeping paper towels and other items stocked within the facility.	N 612		
{N 637}	83.59(1)(g) Proper exit locations, sidewalks, driveways. All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exits, sidewalks and driveways used for exiting shall be kept free of ice, snow, and obstructions. For facilities serving only ambulatory residents, the CBRF shall maintain a cleared pathway from all exterior doors to be used in an emergency to a public way or safe distance away from the building. For facilities serving semi-ambulatory and non-ambulatory residents, a CBRF shall maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2 primary exits from the building. All other required exits shall have at least a cleared pathway maintained to a public way or safe distance from the building. An exit door or walkway to a cleared driveway leading away from the CBRF also meets this requirement.	{N 637}		

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{N 637}	Continued From page 46 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure exits and driveways used for exiting were kept free of obstructions. One of 3 emergency exits prevented a clear, unobstructed exit path from the facility. This had the potential to affect 8 of 8 residents. Three residents utilized wheelchairs and 1 resident utilized a 4-wheeled walker. This deficiency is being cited for a fourth time. See Statements of Deficiency (SOD) CUOK11, dated 09/20/2021, SOD CUOK12, dated 05/10/2022, and SOD CUOK13, dated 05/23/2023. Findings include: The provider is licensed as a Class CNA (non-ambulatory) CBRF able to serve up to 8 residents within the client groups of emotionally disturbed/mental illness, advanced age, alcohol/drug dependent, physically disabled, traumatic brain injury, developmentally disabled, terminally ill, and irreversible dementia/Alzheimer's. On 01/29/2024, at 10:30 AM, Surveyors toured the facility. Surveyors observed the facility's driveway had multiple potholes and cracked pavement. The driveway had 1 pothole approximately 2 feet by 4 feet. There were multiple areas in the driveway with no pavement or loose gravel. The driveway entrance at the street had 3 potholes approximately 3 feet by 2 feet. On 02/22/2024, at 1:00 PM, Surveyors interviewed Licensee C. Licensee C stated s/he had been trying to get the driveway fixed for the	{N 637}		

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{N 637}	Continued From page 47 past 3 years, and financially had been unable to complete the work. S/He plans to complete the repairs in 2024.	{N 637}		
Y3100	50.09(1)(f) RESIDENT'S RIGHTS IN CERTAIN FACILITIES (2) The department, in establishing standards for nursing homes and community based residential facilities may establish, by rule, rights in addition to those specified in sub. (1) for residents in such facilities. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure each resident had the right to not be recorded, filmed, or photographed. Surveillance cameras were placed around the exterior of the facility, recording common spaces. This had the potential to affect 8 of 8 residents. Findings include: The provider is licensed to serve up to 8 residents in the following client groups: emotionally disturbed/mental illness, advanced age, alcohol/drug dependent, physically disabled, traumatic brain injury, developmentally disabled,	Y3100		

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Y3100	Continued From page 48	Y3100		

terminally ill, and irreversible dementia/Alzheimer's. The census at the time of survey was 8.

On 01/29/2024, at 10:30 AM, Surveyors toured the facility and observed cameras in the following locations:

1. Northwest corner of rear deck
2. Southwest corner of rear deck

On 01/29/2024, at 12:45 PM, Surveyors interviewed Administrator A. Administrator A reported the cameras were viewable at any given time from her/his cell phone. S/He showed Surveyors her/his cell phone and the live feed recording from each of the cameras. The view from the camera located at the northwest corner of the exterior of the facility showed a large portion of the back deck area, a common space used by residents to gather. Numerous amounts of cigarette butts were observed in 2 areas of the rear deck, as well as near the front entrance of the facility. Administrator A stated s/he did not know the cameras were a violation of residents' rights to privacy. S/He had used the cameras to record incidents which have occurred involving residents, or to ensure staff were not sneaking in someone and reported it was for the residents' safety.

On 02/22/2024, at 1:00 PM, Surveyors interviewed Licensee C. Licensee C stated the rear deck was utilized by residents for recreational purposes, to get fresh air, and to socialize. S/He stated, " ...This is their personal space." Licensee C reported s/he thought the code allowed cameras to be set up to view the points of entry, and s/he believed the cameras were setup to only view the points of entry.

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Y3100	Continued From page 49 Licensee C reported s/he had the cameras for security purposes and to monitor staff. Licensee C reported they would disable audio on the cameras and reposition them to view only the entry points of the facility. The provider did not protect residents' privacy. Residents were being recorded on the rear deck and front entrance, when gathering, smoking, and visiting.	Y3100		