STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012717	A. BUILDING: _____ B. WING _____	R-C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY LIVING HOME OPTIONS LLC	215 THIRD ST MONROE, WI 53566

(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 06/27/2023, Surveyor completed a verification visit at Community Living Options LLC, a CBRF in Monroe. Two deficiencies were identified. Both deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) D6FQ11, dated 01/31/2023. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 9	{N 000}		
{N 416}	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure injectables administered by caregivers were delegated by a nurse within the scope of their practice. Resident 2's Novolog insulin was administered 57 times from 06/01/2023 to 06/26/2023 without RN delegation. This is a repeat deficiency. See Statement of Deficiency (SOD) D6FQ11, dated 01/31/2023. Findings include:	{N 416}		

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

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{N 416}	Continued From page 1 On 06/26/2023 at approximately 10:00 a.m., Surveyor interviewed Assistant Administrator E. Assistant Administrator E stated Resident 2 received insulin injections. Surveyor asked Assistant Administrator E if caregivers were delegated by an RN to administer insulin. Assistant Administrator E stated s/he was unsure where Administrator A was at with hiring a nurse. Assistant Administrator E explained that due to short staffing, s/he spent more of his/her time as a caregiver than in the administrative role. At approximately 10:20 a.m., Administrator A informed Surveyor s/he was still looking to hire a nurse. At approximately 10:35 a.m., Licensee F arrived onsite. When Surveyor asked Licensee F if his/her staff was delegated by a RN to administer insulin, Licensee F replied, "No. No one will help me." Licensee F explained that s/he had reached out to other medical facilities and retired nurses, but no one has had interest in the position. At approximately 11:00 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 10/20/2010 with diagnosis of diabetes. Resident 2's physician orders included Novolog (Start Date: 01/15/2023) - Inject per sliding scale 3 times daily with meals (150-200=1 unit, 201-250=3 units, 251-300=5 units, 301-350=7 units, greater than 3504=Call physician). Resident 2's Medication Administration Record (MAR), dated 06/01/2023 to 06/26/2023, indicated caregivers administered Resident 2's insulin 57 times without RN delegation.	{N 416}		

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{N 499}	Continued From page 2	{N 499}		
{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 all cleaning compounds and toxic substances were stored in a secure area. The provider's laundry room door was ajar and unlocked allowing access to laundry detergent and cleaning compounds. This is a repeat deficiency. See Statement of Deficiency (SOD) D6FQ11, dated 01/31/2023. Findings include: The provider is licensed to serve up to 12 residents with diagnoses of irreversible dementia/Alzheimer's disease, developmentally disabled, advanced age, traumatic brain injury, physically disabled and terminally ill. On 06/26/2023 at approximately 10:00 a.m., Surveyor toured the provider's facility. Surveyor observed the provider's laundry room door was ajar, allowing access to the laundry room. The door was self-closing but would "stick" and not latch. There was a lock installed at the top of the door, but it was not engaged. Laundry detergents and cleaning compounds were stored in the laundry room. At approximately 10:20 a.m., Surveyor interviewed Assistant Administrator E and asked if the provider typically locked the laundry room	{N 499}		

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{N 499}	Continued From page 3 door. Assistant Administrator E stated s/he thought Administrator A was going to install a key pad lock, but s/he wasn't sure where Administrator A was on that task. At approximately 10:35 a.m., Surveyor reviewed concern with Licensee F that the facility's laundry room was unlocked. Licensee F replied, "You want staff to lock [the laundry room] every time they are in and out? That is crazy." Licensee F further explained that s/he has left the laundry room unlocked for the past 17 years and had no issues with it being unlocked.	{N 499}		