STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019926	A. BUILDING: _____ B. WING _____	R-C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

(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 11/26/2024, Surveyor conducted a complaint investigation and verification visit at A Colfax Senior Living LLC. The complaint was unsubstantiated. Two violations were identified. Two of 2 violations were repeat deficiencies. See Statement of Deficiencies (SOD) DBX311, dated 07/22/2024. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 50	{N 000}		
{N 239}	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to	{N 239}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019926	A. BUILDING: _____ B. WING _____	R-C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

(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 239}	Continued From page 1 assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 caregivers sampled, Lead Caregiver (LC) E, completed a Department-approved medication course prior to assuming medication responsibilities. This is a repeat violation. See Statement of Deficiencies (SOD) DBX311, dated 07/22/2024. Findings include: On 11/26/2024 at 10:00 AM, Surveyor interviewed LC E. LC E stated s/he was the lead caregiver and responsible for administering medication during his/her shift. Surveyor reviewed LC E's record. LC E was hired on 03/13/2024. The provider's training records and the Wisconsin Training Registry did not include evidence that LC E completed a Department-approved medication class. LC E's file did not include evidence of training exemptions. At 2:40 PM, Surveyor interviewed Executive Director (ED) A, Regional Registered Nurse (RRN) B, Community Nurse (CN) C, and Vice President of Clinical Operations (VP) D. ED A confirmed they did not have evidence LC E completed medication training. CN C stated s/he assumed LC E completed the medication course because the previous community nurse delegated LC E to administer medications. ED A stated LC	{N 239}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019926	A. BUILDING: _____ B. WING _____	R-C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

(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 239}	Continued From page 2 E would complete the medication class in December.	{N 239}		
{N 431}	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019926	A. BUILDING: _____ B. WING _____	R-C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

(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 431}	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the provider did not monitor the health of 3 of 4 sampled residents. Resident 1's bowel movements (BM) were not monitored, resulting in painful constipation. Resident 2's oxygen was not monitored per physician orders, and staff did not follow the provider's policy to intervene when vitals were abnormal. Resident 3's vitals and condition were not monitored after falls in October 2024, per the provider's policy and nurse direction. This is a repeat violation. See Statement of Deficiencies (SOD) DBX311, dated 07/22/2024. Findings include: RESIDENT 1 On 11/26/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 06/27/2024 with diagnoses that included Parkinsonism. Resident 1's last assessment, dated 07/23/2024, indicated Resident 1 needed toileting assistance, had a history of constipation, and required BM monitoring. Resident 1's October and November medication administration record (MAR) indicated s/he had 3 daily scheduled medications and 3 as-needed (PRN) medications for constipation. Resident 1's progress note, dated 08/23/2024, indicated Resident 1 had an episode of constipation, resulting in "a lot of blood. RN (registered nurse), ED (executive director), and	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019926	A. BUILDING: _____ B. WING _____	R-C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

(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 431}	Continued From page 4	{N 431}		

hospice nurse notified. Hospice said two [sic] give [him/her] a stool softener, and watch [his/her] bowel movements."

Surveyor reviewed Resident 1's October and November care tracking sheet, which indicated Resident 1 had long spans of time without a BM. In mid-October, Resident 1 did not have a BM for 10 days, and near the end of October/beginning of November, Resident 1 did not have a BM for 11 days.

A progress note dated 10/23/2024, indicated Resident 1 was not feeling well and stated s/he felt constipated. On 10/25/2024, staff wrote, "Resident hasn't had a bm since last Saturday. RN came to writer with concerns about constipation. Writer administered a PRN and called hospice with concerns."

According to Resident 1's MAR, staff administered Resident 1 one of his/her PRN constipation treatments 1 time in October, on 10/25/2024 at 9:27 AM.

The provider's change of condition protocol included in their POC, indicated any complaints of constipation or no BM in 3 days required one of the following interventions: "Take full set of vitals, including BS (blood sugar) if diabetic...Encourage Fiber...Increase activity...Encourage Fluids... Provide PRN laxative."

The provider did not monitor Resident 1's BMs and provide interventions to alleviate constipation.

RESIDENT 2
On 11/26/2024 at 10:45 AM, ED A provided Surveyor a list of residents that required daily vital monitoring. The list indicated Resident 2 required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019926	A. BUILDING: _____ B. WING _____	R-C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

(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 431}	Continued From page 5 daily oxygen monitoring. Surveyor reviewed the provider's POC, which included a chart of various conditions, interventions, and procedures. The directions on the chart read, "...expectations for communicating and guidance for responses to resident acute changes in condition." The chart indicated that if oxygen saturation was below 90%, staff should "recheck vital signs in 15 minutes if abnormal...Notify Manager/Manager On Call (if)... any abnormal vital signs." Surveyor reviewed Resident 2's vital record dated 10/25/2024 through 11/25/2024. Resident 2's oxygen was below 90% 17 times. The lowest reading was 86% on 11/10/2024 at 9:29 AM. Charting did not indicate staff rechecked Resident 2's oxygen saturation within 15 minutes after any of the 17 times there were abnormal readings. At 2:40 PM, Surveyor interviewed ED A, Regional Registered Nurse (RRN) B, Community Nurse (CN) C, and Vice President of Clinical Operations (VP) D. CN C stated s/he was new to his/her position (hired 08/26/2024), and Resident 2's daily monitoring was in place before s/he took over clinical oversight at the facility. CN C stated s/he was unsure why Resident 2 had orders for daily monitoring or when Resident 2's physician needed to be contacted. CN C stated staff were trained to notify CN C when vitals were outside normal levels. VP D stated the provider had standard procedures within their written POC. Surveyor reviewed the provider's POC with the managers and asked if anyone was notified when Resident 2's oxygen saturation was below 90%. CN C stated s/he was not. The provider did not monitor Resident 2's oxygen	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019926	A. BUILDING: _____ B. WING _____	R-C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

(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 431}	Continued From page 6 levels or follow health monitoring procedure. RESIDENT 3 On 11/26/2024 at 9:56 AM, Surveyor interviewed Resident 3. Resident 3 stated s/he recently returned to the facility after a traumatic fall. Resident 3 stated s/he had terrible balance but s/he chose to continue to transfer him/herself despite being assessed as needing transfer assistance. Surveyor reviewed Resident 3's record. Resident 3 was admitted on 04/05/2024 with Type 2 diabetes with diabetic polyneuropathy, weakness, and syncope and collapse. Resident 3 was prescribed blood thinners. In October 2024, Resident 3 had 2 falls. The provider implemented the following monitoring post falls: - 10/23/2024 to 10/27/2024, "72 Hour Monitoring. At Risk of Fall, monitor post fall vitals and for injury. Chart every shift." - 10/27/2024 to 10/29/2024, "72 Hour Monitoring. Monitor and document vitals, monitor for change in cognition, document every shift." A fall report dated 10/27/2024, indicated Resident 3's fall on 10/27/2024 resulted in a "golf ball sized goose egg on resident's right side of [his/her] forehead." The incident report read, "...resident was refusing to go to the hospital, and RN told staff to monitor resident very frequently, and to take [his/her] vitals every 4 hours. As well as document absolutely everything." A progress note dated 10/27/2024, read, "vitals are to be taken EVERY FOUR HOURS." Surveyor reviewed Resident 3's vital record and	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019926	A. BUILDING: _____ B. WING _____	R-C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A COLFAX SENIOR LIVING LLC	110 PARK DR COLFAX, WI 54730

(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 431}	Continued From page 7 did not find evidence Resident 3's vitals were obtained after falls on 10/23/2024 or 10/27/2024. According to progress notes between 10/27/2024 and 11/22/2024, Resident 3 continued to refuse to go to the emergency room. Staff documented Resident 3's condition twice after the fall; once on 10/27/2024 to indicate Resident 3 refused to let staff check his/her vitals, and once on 10/28/2024 to note Resident 3 was complaining of back pain. A note on 10/29/2024 indicated Resident 3 was admitted to the hospital on 10/29/2024 with a subdural hematoma, and subsequent notes from CN C indicated Resident 3 was transferred to a skilled nursing facility for rehabilitation, and returned to the facility on 11/22/2024. At 2:40 PM, Surveyor interviewed ED A, RRN B, CN C, and VP D. CN C stated staff were directed to monitor resident vitals every shift for 72 hours after a fall. Surveyor asked if Resident 3's vitals were monitored after his/her falls on 10/23/2024 and 10/27/2024. CN C stated staff would have documented the vitals in progress notes. CN C and RRN B reviewed Resident 3's record, and both stated they could not locate evidence Resident 3's vitals were monitored after either fall. The provider did not monitor Resident 3's condition after falls.	{N 431}		