| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0017088 | A. BUILDING: _____ B. WING _____ | R-C 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LEGACY ASSISTED LIVING | N26W26511 COLLEGE AVE PEWAUKEE, WI 53072 |

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| {N 000} | Initial Comments<br><br>On 07/22/2024, Surveyor conducted a complaint investigation, verification visit and standard survey.<br><br>Five deficiencies were identified. Statement of Deficiency (SOD) DSWG13, dated 03/26/2024, was corrected.<br><br>The complaint was substantiated.<br><br>Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed.<br><br>Census: 12 | {N 000} | | |
| N 220 | 83.17(2)(a) Employees screened for communicable disease.<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure documentation was obtained indicating 2 of 3 employees reviewed had been screened for clinically apparent | N 220 | | |

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

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| N 220 | Continued From page 1<br>communicable disease, including tuberculosis, within 90 days before the start of their employment. The provider did not have a tuberculosis test on file for Caregiver K. Caregiver L's tuberculosis test was completed approximately 18 months after his/her hire.<br><br>Findings include:<br><br>On 07/22/2024 at approximately 9:30 a.m., Surveyor reviewed employee records provided by Executive Director H. Records documented the following:<br><br>- Caregiver K was hired on 10/04/2023. Caregiver K's record did not include a tuberculosis test.<br>- Caregiver L was hired on 08/15/2022. Documentation indicated Caregiver L's tuberculosis test was completed on 01/17/2024, approximately 18 months after his/her employment.<br><br>On 07/22/2024 at approximately 12:00 p.m., Surveyor reviewed concern with Executive Director H that 2 of 3 employees reviewed did not have a tuberculosis test completed within 90 days prior to providing care. Executive Director H stated Caregiver L's missing tuberculosis test was caught during an audit and taken care of and Caregiver K's tuberculosis test was missed. | N 220 | | |
| N 409 | 83.37(1)(j) Proof-of-use record.<br><br>Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, | N 409 | | |

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| N 409 | Continued From page 2<br>signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure proof-of-use records were audited on a daily basis.<br><br>Findings include:<br><br>On 07/22/2024 at approximately 11:15 a.m., Surveyor reviewed the provider's medication cart with Caregiver L. Surveyor observed 7 syringes of Morphine Sulfate 20 mg/ml for Resident 8 and 14 syringes of Oxycodone 100/5 ml for Resident 5. Surveyor then requested the schedule II daily audits for July from RN E.<br><br>On 07/22/2024 at approximately 11:30 a.m., Surveyor reviewed the schedule II audits for Resident 8 and Resident 5, dated 07/01/2024 to 07/22/2024. Records indicated daily audits were not completed on 07/02/2024, 07/04/2024, 07/06/2024, 07/07/2024, 07/09/2024 and 07/21/2024. Records listed Resident 8's total syringes of Morphine Sulfate 20 mg/ml as 7.5 from 07/01/2024 to 07/20/2024 and Resident 5's total syringes of Oxycodone 100/5 ml from 07/01/2024 to 07/21/2024 as 14.5.<br><br>On 07/22/2024 at approximately 12:00 p.m., Surveyor reviewed concern with Executive Director H and RN E that Resident 5 and Resident 8's schedule II medication audits were off and not completed daily. RN E acknowledged the syringe count was off by .5 for both residents | N 409 | | |

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| N 409 | Continued From page 3<br>and stated this was due to pharmacy's error entering the count when the dose is .5. RN E did not comment on audits not occurring daily. | N 409 | | |
| N 450 | 83.41(2)(c) Nutrition: menus.<br><br>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.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the provider did not ensure a weekly menu was available to residents and that deviations from the planned menu were documented on the menu.<br><br>Findings include:<br><br>On 07/22/2024, Surveyor conducted a complaint investigation alleging the provider did not follow their menu.<br><br>On 07/22/2024 at approximately 8:20 a.m., Surveyor observed residents finishing up their breakfast in the dining room. Surveyor was unable to locate a paper menu posted in the facility. Surveyor observed an electronic posting that rotated announcements such as the menu, but was unable to locate information for what would be served 07/22/2024.<br><br>On 07/22/2024 at approximately 8:25 a.m., | N 450 | | |

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| N 450 | Continued From page 4<br><br>Surveyor interviewed Cook J. Cook J stated s/he had just gotten back to the facility from 3 days off and that the menu for the week would be posted by activities staff at approximately 9:30 a.m.<br><br>On 07/22/2024 at approximately 9:00 a.m., Surveyor toured the provider's kitchen with Cook J. Cook J stated s/he was the only dietary staff currently employed at the facility so for some meals it was the responsibility of caregivers to heat/prep and serve meals Cook J had made in advance. Cook J stated s/he prepared everything and labeled/provided instructions for caregivers, but would return to work to see food that should have been served was not served. Cook J showed Surveyor Philly cheesesteak and desserts that should have been served over the weekend but remained in the provider's freezer. Cook J stated another challenge to following the menu was that online grocery requests were not always filled due to the grocer's supply.<br><br>On 07/22/2024 at approximately 11:30 a.m., Surveyor reviewed the provider's menus, dated 07/14/2024 to 07/27/2024 with Cook J and Executive Director H. The following was identified:<br><br>- 07/17/2024: Dinner was listed as sausage pasta with sauce and garden salad; however, Cook J stated burgers, brats, beans and potato salad were served instead to test out the facility's grill. The deviation was not documented.<br>- 07/18/2024 Dinner's dessert was listed as banana pudding; however, this was still in the freezer on 07/22/2024. Cook J was unsure what was served instead and a deviation was not documented.<br>- 07/19/2024 Supper listed tator tots as a side; however, Cook J stated these were still in the | N 450 | | |

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| N 450 | Continued From page 5<br>freezer. Executive Director H stated french fries were served instead. The deviation was not documented.<br>- 07/20/2024 Dinner was listed as cold cut sandwich, vegetable plate and potato chips and supper was listed as Philly cheesesteak and potato wedges. Cook J stated the Philly cheesesteak was not served. Executive Director H stated the facility had a cook out of brats and burgers for dinner and cold cut sandwiches, potato salad and coleslaw for Supper. The deviations were not documented on the menu. | N 450 | | |
| N 488 | 83.44(1)(c) Clothes dryers enclosed and vented<br><br>Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure 3 of 3 dryers in the facility had dryer vent tubing that was of rigid material.<br><br>Findings include:<br><br>On 07/22/2024 at approximately 11:45 a.m., Surveyor toured the provider's laundry room with Executive Director H. Surveyor observed 3 of 3 dryers had flexible venting. Executive Director H looked behind the dryers to observe Surveyor's concern and stated, "I wasn't aware there were different kinds." Executive Director H stated s/he would update the maintenance employee to have | N 488 | | |

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| N 488 | Continued From page 6<br>the venting system changed to rigid venting. | N 488 | | |
| N 525 | 83.47(2)(d) Fire drills.<br><br>Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure fire drills were conducted at least quarterly and that documentation included the total evacuation time. The provider conducted 1 fire drill in 2023. Two of 3 fire drills conducted in 2023 and 2024 did not include evacuation time.<br><br>Findings include:<br><br>On 07/22/2024 at approximately 9:00 a.m., Surveyor reviewed the provider's environmental records provided by Executive Director H. Surveyor located the following fire drill records: | N 525 | | |

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| N 525 | Continued From page 7<br><br>- Fire Drill on 12/15/2023 at 10:00 a.m. - No evacuation time.<br>- Fire Drill on 03/13/2024 from 2:00 p.m. - 2:20 p.m.<br>- Fire Drill on 04/26/2024 at 4:00 p.m. - No evacuation time.<br><br>On 07/22/2024 at approximately 12:00 p.m., Surveyor reviewed concern with Executive Director H that fire drills were not conducted quarterly in 2023 and fire drill documentation did not always include evacuation time. Executive Director H stated s/he did not have additional fire drills to provide and made note to ensure evacuation times were documented moving forward. | N 525 | | |