STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 09/25/2024, Surveyors conducted a licensure survey, verification visit, and 6 complaint investigation at The Homeplace. Data collection continued through 10/25/2024. One of 6 complaints were substantiated. Eighteen deficiencies were identified. One of the 18 were repeat violations. See Statement of Deficiency (SOD) S75L13, dated 05/10/2022, and SOD DTGP12, dated 02/06/2024. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 28	{N 000}		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure an	N 214		

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
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 214	Continued From page 1	N 214		

administrator supervised the daily operation of the facility, programming, and personnel, in a way that ensured residents received proper care and treatment.

Findings include:

From 04/24/2024 to 09/10/2024, the Department received 6 complaints regarding program services, resident rights, staff training, and environmental concerns.

On 09/25/2024 at 5:20 AM, Surveyors entered the Community Based Residential Facility (CBRF). Surveyors interviewed Caregiver O on the third floor and requested s/he let Community Director (CD) G know Surveyors were in the building. Caregiver O confirmed s/he texted CD G and CD G responded back.

On 09/25/2024 at 6:33 AM, Surveyor interviewed Caregiver D. Caregiver D stated s/he would not approach CD G with any staff concerns because then the other staff would know. Caregiver D stated that if s/he went to CD G for an emergency concern, CD G usually have an attitude issue and would "jump down his/her throat." Caregiver D stated s/he also felt CD G did not address staff concerns and would not text staff back.

On 09/25/2024 at approximately 8:15 AM, Surveyors called Chief Operating Officer (COO) A to inquire about CD G, as s/he had not arrived at the facility and Surveyors were unable to obtain some documentation from staff. COO A stated s/he spoke to CD G on the phone. COO A stated CD G was dropping off his/her child at daycare and was supposed to be arriving at the facility. COO A did not know when CD G would arrive and/or if s/he would arrive at all.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 214	Continued From page 2 On 09/25/2024 at 8:54 AM, CD G arrived at the provider and was upset. CD G stated this was his/her last day of employment with the provider but would help obtain documentation for Surveyors. On 9/25/2024 at approximately 1:00 PM, CD G left the provider with a box of his/her belongings after Surveyors obtained login information for the electronic charting system. On 09/25/2024 at approximately 1:30 PM, Surveyors updated COO A and discussed the plan moving forward with the survey. On 10/09/2024 at 4:28 PM, Surveyor interviewed Adult Protective Services (APS) P. APS P stated s/he spoke to CD G in person on 06/13/2024 during an investigation and CD G was rude and defensive to him/her and the officer accompanying him/her. On 10/10/2024 at 2:03 PM, Surveyor interviewed Power of Attorney (POA) Q. POA Q stated it was his/her first time as a POA and s/he would have liked more communication from the provider about enrolling Resident 2 on hospice (per the hospital discharge orders), upon admission, to provide better pain control and comfort to Resident 2. POA Q stated s/he felt Resident 2's care was not a priority at the provider and hated leaving him/her there. POA Q stated s/he was disappointed with his/her experience. Between 09/25/2024 and 10/25/2024, the Department identified the following concerns: - New employees were not screened for communicable illness prior to working with residents.	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 214	Continued From page 3 - Staff did not complete minimum training requirements. - Residents were not provided with an admission agreement upon admission - Residents were not appropriately screened for communicable disease upon admission - Residents did not get an explanation of rights and grievance procedures upon admission. - Residents did not receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. -Residents did not receive prompt and adequate treatment when condition changed. - Individual service plans were not completed or updated when resident needs changed. - Residents did not receive the option to complete yearly satisfaction surveys - Initial evaluation of resident evacuations limits were not being completed. - Annual evaluation of resident evacuation limits were not being completed or updated when there were changes in condition - Annual medication regimens and administration reviews were not being completed -Scheduled and PRN (as needed) psychotropic medication reviews were not being completed. -Food was not being stored under sanitary conditions for the prevention of food borne illnesses. On 10/25/2024 at 10:30 AM, Surveyors interviewed COO A. COO A stated this was his/her first experience with a CD walking out on the job. COO A stated they were already searching for a new candidate. COO A stated s/he was astonished at the number of concerns staff spoke up about CD G after s/he left employment. COO A stated s/he had noticed 2 to 3 weeks prior to the day of survey, a pattern of CD G not presenting him/herself to work on	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 214	Continued From page 4 certain days or not answering staff's calls after hours. COO A stated it was CD G's responsibility to make sure the issues were fixed from the previous Statement of Deficiency. COO A stated that after attempting to collect documentation for Surveyors, s/he started to see issues and would be taking a deeper dive into things to bring them back into compliance. Cross References: 83.17(2)(a) Employees Screened For Communicable Disease 83.19 Orientation 83.21(1)-(3) All Employee Training 83.22(1)-(4) Task Specific Training 83.25 Continuing Education 83.28(3) Provide Admission Agreement As Required 83.28(4)(a) Resident Health Screening And Documentation 83.32(2)(a) Explanation Of Rights, Grievance Procedure 83.32(3)(h) Rights Of Residents: Receive Medication 83.32(3)(i) Rights Of Residents: Adequate Treatment 83.35(4) Resident Satisfaction Evaluation 83.35(5)(a) Initial Evaluation Of Evacuation Limitations 83.35(5)(b) Annual Evaluation Of Evacuation Limits 83.37(1)(e) Medication Regimen, Administration Review 83.37(1)(h) Scheduled Psychotropic Medications 83.37(1)(i) Prn Psychotropic Medication 83.41(3)(b) Food Safety	N 214		
N 220	83.17(2)(a) Employees screened for communicable disease.	N 220		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 220	Continued From page 5 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 obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse, indicating all employees had been screened for clinically apparent communicable disease including tuberculosis (TB). Findings include: On 09/25/2024, Surveyor requested employee records. Caregiver D was hired on 06/10/2024. Caregiver D's record contained a communicable disease screening and TB test dated 06/13/2024. Caregiver D's communicable disease screen and TB test were both completed by Community Director (CD) G. CD G was a Licensed Practical Nurse (LPN). Caregiver E was hired on 01/22/2024. Caregiver	N 220		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 220	Continued From page 6 E's record contained a communicable disease screening and TB test dated 01/25/2024. Caregiver E's communicable disease screen and TB test were both completed by Community Director (CD) G. On 10/17/2024, at approximately 9:00 AM, Surveyors interviewed Community Director (CD) G. CD G stated that upon hire, s/he or Chief Operating Officer (COO) A would administer the TB test to new employees and conduct the communicable disease screening. CD G and COO A were both LPNs and not registered nurses.	N 220		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 4 employees sampled (Caregiver B, Caregiver C, Caregiver D, and Caregiver E), received orientation training in	N 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 230	Continued From page 7 the following topics: job responsibilities; prevention and reporting of resident abuse, neglect and misappropriation of resident property; information regarding assessed needs and individual services for each resident for whom the employee is responsible; emergency and disaster plan and evacuation procedures, CBRF policies and procedures; recognizing and responding to resident changes of condition; prior to assuming job duties. Findings include: On 09/25/2024, Surveyor reviewed employee records. Caregiver B was hired on 11/03/2021. There was no evidence of any orientation training in the required topics prior to assuming job duties. Caregiver C was hired on 02/09/2021. There was no evidence of any orientation training in the required topics prior to assuming job duties. Caregiver D was hired on 06/10/2024. There was no evidence of any orientation training in the required topics prior to assuming job duties. Caregiver E was hired on 01/22/2024. There was no evidence of any orientation training in the required topics prior to assuming job duties. On 10/17/2024, at approximately 9:00 AM, Surveyors interviewed Community Director (CD) G. CD G stated all new hires went through an extensive orientation process. S/he stated Human Resources (HR) F did day 1 of orientation. CD G stated that on day 1, employees would go through all the policies and procedures with HR F.	N 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 230	Continued From page 8 On 10/25/2024 at 10:30 AM, Surveyor interviewed Chief Operating Officer (COO) A. COO A stated that after reviewing staff training documentation sent to Surveyors, s/he would be doing a deeper dive as s/he started to see issues. COO A stated s/he struggled to find documentation after CD G left employment on the day of survey. COO A confirmed it was CD G's responsibility to make sure staff had completed all their required training.	N 230		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 243	Continued From page 9 employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure 4 of 4 employees reviewed, obtained all training as required, within 90 days after starting employment. Caregiver B, C, D, and E did not have training in resident rights within 90 days after starting employment. Caregiver B, C, D, and E did not have training in recognizing, preventing, managing and responding to challenging behaviors within 90 days after starting employment. Caregiver B, D, and E did not have training in required client groups within 90 days after starting employment. Findings include:	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 243	Continued From page 10 On 09/25/2024, Surveyor requested training records from Human Resources Director F for Caregiver B, C, D, and E. Resident Rights The record for Caregiver B, hired 11/03/2021, did not contain evidence of training or evidence of meeting an exemption for resident rights. The record for Caregiver C, hired 02/09/2021, did not contain evidence of training or evidence of meeting an exemption for resident rights. The record for Caregiver D, hired 06/10/2024, did not contain evidence of training or evidence of meeting an exemption for resident rights. The record for Caregiver E, hired 01/22/2024, did not contain evidence of training or evidence of meeting an exemption for resident rights. On 10/25/2024 at 10:30 AM, Surveyor interviewed Chief Operating Officer (COO) A. COO A confirmed the provider did not have evidence that Caregiver B, C, D, and E completed or met an exemption for resident rights training. Recognizing, Preventing, Managing and Responding to Challenging Behaviors The record for Caregiver B, hired 11/03/2021, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training.. The record for Caregiver C, hired 02/09/2021, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 243	Continued From page 11 training. The record for Caregiver D, hired 06/10/2024, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. The record for Caregiver E, hired 01/22/2024, did not contain evidence of training or evidence of meeting an exemption challenging behaviors training. On 10/25/2024 at 10:30 AM, Surveyor interviewed COO A. COO A confirmed the provider did not have evidence that Caregiver B, C, D, and E completed or met an exemption for challenging behaviors training. Client Group The facility was licensed to provide care and services to residents within the client groups of advanced aged and irreversible dementia/Alzheimer's disease. The record for Caregiver B, hired 11/03/2021, did not contain evidence of training or evidence of meeting an exemption for client group training specific to advanced aged and irreversible dementia/Alzheimer's disease. The record for Caregiver D, hired 06/10/2024, did not contain evidence of training or evidence of meeting an exemption for client group training specific to advanced aged and irreversible dementia/Alzheimer's disease. The record for Caregiver E, hired 01/22/2024, did not contain evidence of training or evidence of meeting an exemption for client group training	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 243	Continued From page 12 specific to advanced aged and irreversible dementia/Alzheimer's disease. On 10/25/2024 at 10:30 AM, Surveyor interviewed COO A. COO A confirmed the provider did not have evidence that Caregiver B, D, and E had completed or met an exemption for client group training specific to advanced aged and irreversible dementia/Alzheimer's. COO A stated that after reviewing staff training documentation sent to Surveyors, s/he would be doing a deeper dive as s/he started to see issues. COO A stated s/he struggled to find documentation after CD G left employment on the day of survey. COO A confirmed it was CD G's responsibility to make sure staff had completed all their required training.	N 243		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 247	Continued From page 13 and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 4 employees obtained all task specific training. Caregiver E, who had responsibilities for providing assistance with activities of daily living, did not have training in the provision of personal care, prior to assuming these duties. Caregiver B, D, and E, who perform dietary duties, did not have training in dietary services within 90 days after assuming job duties. Findings include: On 09/25/2024, Surveyor conducted a review of 4 employees to verify compliance with task specific training requirements. Surveyor requested	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 247	Continued From page 14	N 247		

training records from Human Resources Director F for Caregiver B, C, D, and E.

Provision of Personal Care
The record for Caregiver E, hired 01/22/2024, did not contain evidence of training or evidence of meeting an exemption for personal care training.

On 10/25/2024 at 10:30 AM, Surveyor interviewed Chief Operating Officer (COO) A. COO A confirmed the provider did not have evidence that Caregiver E completed or met an exemption for provision of personal care training prior to assuming these job duties.

Dietary Training
The record for Caregiver B, hired 11/03/2021, did not contain evidence of training or evidence of meeting an exemption for dietary training.

The record for Caregiver D, hired 06/10/2024, did not contain evidence of training or evidence of meeting an exemption for dietary training.

The record for Caregiver E, hired 01/22/2024, did not contain evidence of training or evidence of meeting an exemption for dietary training.

On 10/25/2024 at 10:30 AM, Surveyor interviewed COO A. COO A confirmed the provider did not have evidence that Caregiver B, D, and E completed or met an exemption for provision of personal care training, prior to assuming job duties. COO A stated that after reviewing staff training documentation sent to Surveyors, s/he would be doing a deeper dive, as s/he started to see issues. COO A stated s/he struggled to find documentation after CD G left employment on the day of survey. COO A confirmed it was CD G's responsibility to make

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 247	Continued From page 15 sure staff had completed all their required training.	N 247		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Caregiver B and C received 15 hours of continuing education per calendar year beginning with the first full calendar year of employment, for 2 of 2 staff reviewed. Findings include: On 09/25/2024, Surveyor reviewed training records for Caregiver B and C. Caregiver B did not have 15 hours of continuing education in the following areas: standard precautions, client group related training, resident rights, prevention and reporting of abuse, neglect and misappropriation, fire safety, and emergency procedures (including first aid).	N 277		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 277	Continued From page 16 Caregiver B was hired on 11/03/21. Caregiver B received training on medications in both 2022 and 2023. There was no documentation of how many hours this training took Caregiver B. Caregiver C did not have 15 hours of continuing education in the following areas: standard precautions, client group related training, medications, resident rights, prevention and reporting of abuse, neglect and misappropriation, fire safety, and emergency procedures (including first aid). Caregiver C was hired on 02/09/21. Caregiver C had no evidence of any continuing education in 2022 or 2023. On 10/17/2024, at approximately 9:00 AM, Surveyors interviewed Community Director (CD) G. CD G stated they did all of the continuing education through a system called ALEA. CD G stated s/he only got notified when staff were falling behind on their trainings. S/he stated s/he was only notified one time that a staff member was behind on yearly trainings. On 10/25/2024 at 10:30 AM, Surveyor interviewed Chief Operating Officer (COO) A. COO A stated that after reviewing staff training documentation sent to Surveyors, s/he would be doing a deeper dive, as s/he started to see issues. COO A stated s/he struggled to find documentation after CD G left employment on the day of survey. COO A confirmed it was CD G's responsibility to make sure staff had completed all their required training. Caregiver B and C did not receive 15 hours of continuing education per calendar year, beginning	N 277		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 277	Continued From page 17 with the first full calendar year of employment with the provider.	N 277		
N 301	83.28(3) Provide admission agreement as required. Admission agreement. Before or at the time of admission, the CBRF shall provide the admission agreement as required under s. DHS 83.29(2). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an admission agreement was completed before or at the time of admission for 3 of 5 (Resident 3, Resident 4, and Resident 7) resident records reviewed. Findings include: On 09/25/2024, Surveyor reviewed records for Resident 3, Resident 4, and Resident 7. Surveyor identified the following: Resident 3 was admitted to the facility on 09/06/2024. Resident 3's record did not include a signed admission agreement. Resident 4 was admitted to the facility on 06/12/2024. Resident 4's record did not include a signed admission agreement. Resident 7 was admitted to the facility on 04/25/2024. Resident 7's record did not include a signed admission agreement. On 10/17/2024 at 9:00 AM, Surveyor interviewed Community Director (CD) G. CD G stated the	N 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 301	Continued From page 18 admission agreements were done in person if the resident's guardian or power of attorney (POA) was present on the day of admission. CD G stated that if the resident's guardian or POA were not present on the day of admission, then s/he would send the admission agreement to be signed. On 10/24/2024 at 10:30 AM, Surveyor interviewed Chief Operating Officer (COO) A. COO A stated s/he struggled to find documentation after CD G left employment on the day of survey. Cross References: 83.28(4)(a) Resident Health Screening And Documentation 83.32(2)(a) Explanation Of Rights, Grievance Procedure. 83.35(5)(a) Initial Evaluation Of Evacuation Limitations.	N 301		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record.	N 302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 302	Continued From page 19	N 302		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 5 of 5 (Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7) residents were screened for clinically apparent communicable disease, including tuberculosis (TB).

Findings include:

On 09/25/2024, Surveyor reviewed records for Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7. Surveyor identified the following:

Resident 3 was admitted to the facility on 09/06/2024. Resident 3's record did not include a health screening for communicable disease or a TB test.

Resident 4 was admitted to the facility on 06/12/2024. Resident 4's record did not include a health screening for communicable disease or a TB test.

Resident 5 was admitted to the facility on 03/09/2022. Resident 5's record did not include a health screening for communicable disease. Resident 5's record did include a health screening for communicable disease dated 07/26/2023, over 1 year after admission.

Resident 6 was admitted to the facility on 06/15/2023. Resident 6's record did not include a health screening for communicable disease or a TB test.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 302	Continued From page 20 Resident 7 was admitted to the facility on 04/25/2024. Resident 7's record did not include a health screening for communicable disease or a TB test. On 10/17/2024 at 9:00 AM, Surveyor interviewed Community Director (CD) G. CD G stated that before admission, s/he would make sure a resident had a chest x-ray or TB test done. CD G stated the Physician Plan of Care (PPOC) was considered the health screening for communicable disease. On 10/24/2024 at 10:30 AM, Surveyor interviewed Chief Operating Officer (COO) A. COO A stated s/he struggled to find documentation after CD G left employment on the day of survey.	N 302		
N 343	83.32(2)(a) Explanation of rights, grievance procedure. Explanation of resident rights, grievance procedure, and house rules. Before the admission agreement is signed by the resident or the resident ' s legal representative or at the time of admission, the CBRF shall provide a copy of and explain resident rights, the grievance procedure under s. HFS 83.33 and the house rules to the person being admitted, the person ' s legal representative, and family members of the person. The resident or the resident ' s legal representative shall be asked to sign a statement to acknowledge the receipt of an explanation of resident rights. The CBRF shall document the date and to whom the information was provided.	N 343		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 343	Continued From page 21 This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain a signed statement acknowledging the provider explained resident rights, grievance procedure, and house rules to residents, for 2 of 5 resident records reviewed. Findings include: On 09/25/2024, Surveyor reviewed records for Resident 4 and Resident 7. Surveyor identified the following: Resident 4 was admitted to the facility on 06/12/2024. Resident 4's record did not include documentation indicating resident rights, grievance procedures, and house rules were explained to or signed by Resident 4 upon admission. Resident 7 was admitted to the facility on 09/06/2024. Resident 7's record did not include documentation indicating resident rights, grievance procedures, and house rules were explained to or signed by Resident 7 upon admission. On 10/07/2024 at 12:03 PM, Surveyor received an email from Chief Operating Officer (COO) A that read, in part, "We do not have handbook signatures for [Resident 4] or [Resident 7]." On 10/17/2024 at 9:00 AM, Surveyor interviewed Community Director (CD) G. CD G stated the resident rights document was in the admission packet and s/he would discuss the grievance procedure and house rules at admission. On 10/24/2024 at 10:30 AM, Surveyor interviewed Chief Operating Officer (COO) A.	N 343		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 343	Continued From page 22 COO A stated s/he struggled to find documentation after CD G left employment on the day of survey.	N 343		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 4 and Resident 7 received all prescribed medications in the dosage and at intervals prescribed by a practitioner. This is a repeat deficiency. See Statement of Deficiency (SOD) S75L13, dated 05/10/2022, and SOD DTGP12, dated 02/06/2024. Findings include: This facility is licensed to care for 33 residents in the client groups, Irreversible dementia/Alzheimer's disease, and Advanced aged. RESIDENT 4 Resident 4 was admitted 06/12/2024. His/her diagnoses included: type 2 diabetes, hyperlipidemia, vascular dementia, schizoaffective disorder, sleep apnea, hypertension, hemiplegia and hemiparesis	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 352}	Continued From page 23 following cerebral infarction affecting unspecified side, fatty liver, and chronic kidney disease. Resident 4's medication administration record (MAR) showed a scheduled medication, Azithromycin 250 mg tablet with a start date of 07/28/2024. The directions stated, "Take 2 tablets by Mouth today Then 1 Tablet Daily for the Next Four Days." The MAR showed Resident 4 received his/her first dose at 8 PM on 07/28/2024. Resident 4 then received the proper dose of Azithromycin for the next 4 days. In Resident 4's MAR, under the scheduled time of 8 PM, it was then noted "other" from 8/2-8/7. The MAR also showed Resident 4 received the medication again from 8/8-8/11, as well as 8/15. RESIDENT 7 Resident 7 was admitted on 04/25/2024. Resident 7's MAR showed a scheduled medication, Cephalexin 500 mg capsule. Directions read: "Take 1 Capsule by Mouth 2 Times Daily for 7 days," with a start date of 09/11/2024. Resident 7 did not receive the 8 AM or 8 PM dose of Cephalexin on 09/11/2024. The medication was then administered at both 8 AM and 8 PM from 09/12/2024- 09/18/2024. The resident then received the 8 AM dose from 9/19-9/25/2024. Resident 7 received 7 additional morning doses of Cephalexin. On 10/17/2024, at approximately 9 AM, Surveyors interviewed Community Director (CD) G. CD G stated that when antibiotic cards arrive to the facility, they would only come with the scheduled number of doses. CD G stated that this appeared to be a staff charting issue. CD G	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 352}	Continued From page 24 stated s/he did not believe the resident got extra doses but that staff just charted it without giving it. CD G stated that it was very frustrating. On 10/25/2024 at 10:30 PM, Surveyor interviewed Chief Operating Officer (COO) A. COO A stated that if an antibiotic order did not have an end date attached to the order, then it would just continue in the MAR and not end after so many days. COO A stated that if staff did not pay attention, they would just mark as given and continue on. COO A stated, ideally, floor supervisors would have one office day per week to audit the MARs weekly and CD G would do random MAR audits.	{N 352}		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received prompt and adequate treatment on 05/31/2024, when s/he experienced an unwitnessed fall on the evening shift that was not reported by staff. Resident 1 was found by staff in intense pain the morning of 06/01/2024, and sent in to be medically evaluated. Findings include: On 06/20/2024, the Department received a	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 353	Continued From page 25	N 353		

complaint related to the provider's response to changes in a resident's condition.

The provider is licensed to care for 33 residents in the client groups irreversible dementia/Alzheimer's disease and advanced aged.

On 09/25/2024, Surveyor requested to review Resident 1's record, including face sheet, individual service plan (ISP), care history, and incident reports.

Resident 1 was admitted to the facility on 04/20/2024 and discharged on 06/03/2024. Resident 1 had a power of attorney (POA) and diagnoses that included chronic kidney disease stage 3, dementia, anxiety, history of deep vein thrombosis with anticoagulation medication, and osteoporosis.

The ISP, dated 05/14/2024, indicated Resident 1 needed full assistance with toileting and was on 2-hour toilet checks to prevent skin breakdown. The ISP indicated Resident 1 may get up during the night but would need no staff assistance. The ISP indicated Resident 1 needed minimal instruction and/or reminders from staff with transfers, was a stand-by assist with ambulation, and was unsteady on his/her feet. The ISP read, in part, "[Resident 1] has chronic pain. [S/he] may be unable to verbalize pain. [S/he] takes tramadol at bedtime and as needed ...[Resident 1] may be unable to verbalize if [s/he] is feeling ill or has noticed change." The ISP indicated Resident 1 was a high risk for falls due to his/her age, medications, and disease processes. Resident 1 was pleasantly confused.

An incident report, dated 06/05/2024 and written

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 353	Continued From page 26 by Community Director (CD) G, indicated Resident 1 had a fall on the evening shift in his/her apartment. The incident report indicated 2 staff (Caregiver J and Caregiver K) assisted Resident 1 up off the floor. Caregiver J and Caregiver K did not complete an incident report after the fall, document the fall in the electronic medical record, or notify on-call staff. An investigation summary indicated Resident 1 had a fall between dinnertime and bedtime. The Investigation summary indicated Resident 1 was discovered with "intense" pain the morning of 06/01/2024 by Caregiver L, who updated on-call staff. Caregiver L made a statement indicating s/he was not told about Resident 1 having a fall or injury from the previous staff and nothing was documented. The investigation summary indicated the overnight staff, Caregiver M, gave Resident 1 pain medication at about 1:40 AM on 06/01/2024, and observed Resident 1 was shaky. A statement, dated 05/31/2024 and written by Caregiver K, indicated Caregiver K was called in to assist Caregiver J with Resident 1's fall. Caregiver K indicated s/he assisted Caregiver J with getting Resident 1 off the floor and back into bed. Caregiver K indicated Caregiver J assessed Resident 1 and stated "S/he appeared to be ok." Caregiver K indicated Resident 1 did show minor pain. Text messages dated 06/02/2024, between CD G and Caregiver J, indicated Caregiver J did not have any information about Resident 1's fall or change in condition and had resigned employment. The staff progress notes indicated there was only one staff note on 05/31/2024 at 4:20 AM,	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 353	Continued From page 27	N 353		

indicating Resident 1 was asleep. The staff progress notes for 06/01/2024 indicated the following:

06/01/2024 at 1:45 AM - "[S/he] had a PRN (as needed) Tramadol @ 1:40 am [sic] [s/he] had pain in [his/her] left hip and thigh area. 3rd floor staff thinks [s/he] may need to sleep with [his/her] left leg not underneath the right leg [sic] when staff went to bring the PRN [s/he] was in that same position again though."

06/01/2024 at 8:45 AM - "Staff went in at 730am [sic] and found [Resident 1] in pain. Contacted other staff to bring [him/her] a PRN Tramadol as well as called [POA l] right away. [Resident 1] was having pain in [his/her] left hip, it hurt [him/her] to move [his/her] left leg. EMS (emergency medical services) was called for [him/her] to be sent out. [Resident 1] is going to [hospital]. [Resident 1] stated [s/he] fell last night in the living room. [Community Director (CD) G] was notified of [Resident 1] being sent out to [hospital]."

06/01/2024 at 9:30 AM - "When the backup staff on this floor went into this residents [sic] room to get [him/her] up and ready for breakfast, [s/he] radioed this staff and asked for a PRN of Tramadol. When writer arrived in this residents [sic] room, [s/he] was laying [sic] on the bed and appeared to be in pain. Other staff was unable to get [him/her] to sit up due to extreme pain in [his/her] right hip and leg. [S/he] was given the PRN and [his/her] regular AM medications. Staff was going to come and see [him/her]. On call notified [POA l] and [s/he] stated that [s/he] was going to come and see [him/her]. Within a few minutes [POA l] called back and stated that [s/he] wanted [Resident 1] sent out. An ambulance was called. [POA l] arrived just before the ambulance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 353	Continued From page 28 The resident did state to the other staff that [s/he] fell yesterday in [his/her] living area ...[S/he] left the facility at approximately 8:30am [sic]." The toileting care history, dated 05/31/2024 to 06/01/2024, indicated staff charted Resident 1 was toileted at 2:24 PM on 05/31/2024 and 12:09 AM on 06/01/2024; a gap of about 9.5 hours. Staff also charted Resident 1 was toileted at 12:23 AM, 2:10 AM, 04:19 AM, and 8:39 AM, on 06/01/2024. The EMS report indicated EMTs (emergency medical technicians) were called on 06/01/2024 at 7:53 AM, to respond to Resident 1's change in condition. The report indicated a left hip fracture was suspected from Resident 1's fall approximately 12 hours prior. The report indicated Resident 1 was found at 7:30 AM, in 10 out of 10 rated pain, and presented with his/her left leg bent under his/her right leg. A hospital discharge summary, dated 06/06/2024, indicated Resident 1 received surgical repair for a closed left hip fracture. Resident 1 was discharged to a skilled nursing facility for rehabilitation. On 10/04/2024 at 1:37 PM, Surveyor interviewed POA I. POA I stated s/he never received a phone call about Resident 1's fall until 7:32 AM on 06/01/2024. POA I stated that when s/he arrived at the facility, s/he could hear Resident 1 screaming in pain before POA I got off the elevator. POA I stated that when s/he observed Resident 1, it was obvious that Resident 1's left leg was broken. On 10/11/2024 at 12:42 PM, Surveyor interviewed Caregiver M. Caregiver M confirmed s/he gave	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 353	Continued From page 29	N 353		

Resident 1 a tramadol at 1:40 AM on 06/01/2024. Caregiver M stated Resident 1 was shaking his/her head "yes" when asked if in pain and s/he was grabbing his/her left leg. Caregiver M stated s/he observed Resident 1 had his/her right leg crossed over his/her left leg.

On 10/17/2024 at 8:08 AM, Surveyor interviewed Case Manager (CM) N. CM N stated s/he was initially notified about Resident 1's fall from POA I by voicemail.

On 10/17/2024 at 9:00 AM, Surveyor interviewed CD G. CD G stated s/he did not complete an assessment on Resident 1 prior to him/her leaving the facility to be medically evaluated. CD G stated POA I was notified the morning of 06/01/2024, when staff called to ask about sending Resident 1 to be medically evaluated. CD G stated s/he was unsure when CM N was notified about Resident 1's fall on 05/31/2024.

On 10/25/2024 at 10:30 AM, Surveyor interviewed Chief Operating Officer (COO) A. COO A stated Caregiver J and Caregiver K were both new employees hired within a month prior to Resident 1's fall on 05/31/2024. COO A confirmed Caregiver J and Caregiver K were trained on the fall policy and procedure upon hire. COO A stated Caregiver J and Caregiver K did not report Resident 1's fall and should not have waited for a legal representative to respond before sending a resident out for a change in condition.

The provider did not ensure Resident 1 received prompt and adequate treatment on 05/31/2024, when s/he experienced an unwitnessed fall and staff failed to report it. Staff did not send Resident 1 in to be medically evaluated until the next morning on 06/01/2024 (approximately 12 hours

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 353	Continued From page 30 later), when s/he was found with pain rated as 10 out of 10. Resident 1 had surgical repair on a closed left hip fracture and was discharged to a skilled nursing facility for rehabilitation.	N 353		
N 392	83.35(4) Resident satisfaction evaluation. Satisfaction evaluation. At least annually, the CBRF shall provide the resident and the resident ' s legal representative the opportunity to complete an evaluation of the resident ' s level of satisfaction with the CBRF ' s services. The evaluation shall be completed on either a department form or a form developed by the CBRF and approved by the department. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide the resident and the resident's legal representative the opportunity to complete an evaluation, at least annually, of the resident's level of satisfaction with the provider's services, for 1 of 2 (Resident 5) residents reviewed. Findings include: On 09/25/2024, Surveyor reviewed records for Resident 5. Surveyor identified the following: Resident 5 was admitted to the facility on 03/09/2022. Resident 5's record did not contain evidence to show a satisfaction survey was sent to Resident 5 or Resident 5's representative at least annually. On 10/17/2024 at 9:00 AM, Surveyor interviewed Community Director (CD) G. CD G stated s/he would send out satisfaction surveys to residents'	N 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 392	Continued From page 31 legal representatives but did not keep track of which ones s/he got back. On 10/25/2024 at 10:30 AM, Surveyor interviewed Chief Operating Officer (COO) A. COO A stated s/he struggled to find documentation after CD G left employment on the day of survey. COO A stated Human Resources (HR) F now sends out the resident satisfaction surveys but could not find the front pages to demonstrate they were sent.	N 392		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations. Initial evaluation. The CBRF shall evaluate each resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an unsprinklered CBRF and 4 minutes in a sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 5 of 5 (Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7) residents reviewed, were evaluated within 3 days of admission for evacuation capabilities. Findings include:	N 393		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 393	Continued From page 32 On 09/25/2024, Surveyor reviewed records for Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7. Surveyor identified the following: Resident 3 was admitted to the facility on 09/06/2024. Resident 3's record did not contain an initial evaluation of evacuation capabilities. Resident 4 was admitted to the facility on 06/12/2024. Resident 4's record did not contain an initial evaluation of evacuation capabilities. Resident 5 was admitted to the facility on 03/09/2022. Resident 5's record did not contain an initial evaluation of evacuation capabilities. Resident 6 was admitted to the facility on 06/15/2023. Resident 6's record did not contain an initial evaluation of evacuation capabilities. Resident 7 was admitted to the facility on 04/25/2024. Resident 7's record did not contain an initial evaluation of evacuation capabilities. On 10/17/2024 at 9:00 AM, Surveyor interviewed Community Director (CD) G. CD G stated the initial evaluation of evacuation capabilities was done usually on the day of admission with the admission packet. On 10/24/2024 at 10:30 AM, Surveyor interviewed Chief Operating Officer (COO) A. COO A stated s/he struggled to find documentation after CD G left employment on the day of survey.	N 393		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate	N 394		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 394	Continued From page 33 each resident ' s mental or physical capability to respond to a fire alarm at least annually or when there is a change in the resident ' s mental or physical capability to respond to a fire alarm. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 6 was assessed at least annually for evacuation capabilities. Findings include: On 09/25/2024, Surveyor reviewed Resident 6's record. Surveyor identified the following: Resident 6 was admitted to the facility on 06/15/2023. Resident 6's record did not contain an initial evaluation of evacuation capabilities for 2024. On 10/17/2024 at 9:00 AM, Surveyor interviewed Community Director (CD) G. CD G stated the annual evaluation of evacuation capabilities were done on all residents at the beginning of the year or with a change in condition. On 10/24/2024 at 10:30 AM, Surveyor interviewed Chief Operating Officer (COO) A. COO A stated s/he struggled to find documentation after CD G left employment on the day of survey.	N 394		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident	N 404		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 404	Continued From page 34 ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a physician, pharmacist, or registered nurse conducted an onsite review of the provider's medication administration and medication storage systems. Findings include: The provider is licensed to care for 33 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 09/25/2024, Surveyors requested the completed annual reviews of the medication administration and storage systems for the last 2 years. Community Director (CD) G provided an annual medication administration and storage system	N 404		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 404	Continued From page 35 review dated 01/17/24. This review was completed by CD G, who is a licensed practical nurse (LPN). No annual review for 2023 was provided. On 10/02/2024 at approximately 3:45 PM, Surveyor requested the 2023 annual review from Chief Operating Officer (COO) A. COO A stated "Unfortunately, we are unable to locate the 2023 review". On 10/17/2024 at 9:00 AM, Surveyor interviewed CD G. CD G stated it was his/her responsibility to do the annual medication review. On 10/25/2024 at 10:30 AM, Surveyor interviewed COO A. COO A stated Registered Nurse (RN) H was responsible for doing the annual medication review. COO A stated s/he struggled to find documentation after CD G left employment on the day of survey. The provider did not ensure annual medication administration and storage reviews were completed.	N 404		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential	N 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 407	Continued From page 36 benefits and side effects of the medication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were reassessed by a pharmacist, practitioner, or registered nurse as needed, but at least quarterly, for the desired response and possible side effects of scheduled psychotropic medications, for 2 of 2 resident records reviewed. Findings include: On 09/25/2024 at 4:01 PM, Surveyors requested via email from Chief Operating Officer (COO) A, scheduled psychotropic medication reviews for Resident 5 and Resident 6 for 2023 and 2024. On 09/25/2024, Surveyor reviewed Resident 5's and Resident 6's records. Surveyor discovered the following: RESIDENT 5 Resident 5 was admitted to the provider on 03/09/2022. On 09/27/2024 at 2:50 PM, Surveyors received via email from COO A, psychotropic medication reviews for Resident 5. The email contained scheduled quarterly psychotropic medication reviews for Buspirone, dated 01/17/2023, 06/19/2023, 09/30/2023, and 03/24/2024. It also contained scheduled quarterly psychotropic medication reviews for Sertraline, dated 01/17/2023, 04/23/2024, 06/19/2023, 09/30/2023, and 03/24/2024. Resident 5's medication administration record	N 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 407	Continued From page 37 (MAR) indicated Resident 5 received scheduled Sertraline HCL 50 milligrams (mg) tablet once daily, July 2024 through September 2024. Residents 5's MAR indicated Resident 5 received scheduled Buspirone HCL 15 mg tablet twice daily, July 2024 through September 2024. RESIDENT 6 On 09/27/2024 at 2:50 PM, Surveyors received via email from COO A, psychotropic medication reviews for Resident 6. The email contained scheduled quarterly psychotropic medication reviews for Gabapentin, dated 03/24/2024. It also contained scheduled quarterly psychotropic medication reviews for Trazadone, dated 08/31/2023, 11/22/2023, and 03/24/2024. Resident 6 was admitted to the facility on 06/15/2023. Resident 6 had a POAHC that made decisions on his/her behalf. Resident 6's MAR indicated Resident 6 received scheduled Trazodone 50 mg tablet once daily July 2024 through September 2024. Residents 6's MAR indicated Resident 6 received scheduled Gabapentin tablet 300 mg tablet once daily July 2024- September 2024. On 10/17/2024 at approximately 9:00 AM, Surveyors interviewed Community Director (CD) G. CD G stated that Registered Nurse (RN) H was in charge of all psychotropic medication reviews. CD G stated RN H ran and reviewed those reports but was rarely on site. On 10/25/2024 at 10:30 AM, Surveyor interviewed COO A. COO A stated RN H visited the facility 1 to 2 times per month and part of	N 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 407	Continued From page 38 his/her role was to do psychotropic medication reviews. COO A confirmed scheduled psychotropic medication reviews had not been done by RN H since May 2024, and indicated s/he would look further into the concern. Resident 5 and Resident 6 did not have a quarterly psychotropic medication review since March of 2024.	N 407		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that each resident prescribed a psychotropic medication on an as	N 408		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 408	Continued From page 39	N 408		

needed (PRN) basis had, at least monthly, a review to determine if the individual service plan (ISP) had a detailed description of why and when to give the medication. The review is to determine if the drug was given contrary to its intended use and review any negative side effects. This information is to be documented.

Findings include:

The provider is licensed to care for 33 residents within the client groups of advanced aged and irreversible dementia/Alzheimer's disease.

On 09/25/2024, Surveyor reviewed Resident 6's record, including the medication administration record (MAR) from July 2024 to September 2024. Resident 6 was admitted to the facility on 06/15/2023 and had diagnoses that included acute congestive heart failure, hilar adenopathy, multiple sclerosis, and non-ST elevation myocardial infarction. The face sheet indicated Resident 6 was on hospice. The MARs indicated Resident 6 was ordered the following PRN psychotropic medications:

Lorazepam Intensol 2 mg/ml - take 0.25 ml (0.5mg) under the tongue every 4 hours for anxiety, restlessness, and/or agitation.

Morphine Sulfate 20 mg/ml solution - take 0.25 ml orally every 2 hours for shortness of breath and pain.

The MAR indicated both medications were started on 03/07/2024.

On 09/25/2024 at 4:01 PM, Surveyors requested via email from Chief Operating Officer (COO) A, PRN psychotropic medication reviews for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 408	Continued From page 40 Resident 6 from 2023 and 2024. On 09/27/2024 at 2:50 PM, Surveyors received via email from COO A, PRN psychotropic medication reviews for Resident 6. The email contained PRN psychotropic medication reviews for morphine and lorazepam dated 03/30/2024, 04/30/2024, and 05/30/2024. The Medication Management Policy dated July 2024, read, in part, "Monthly the nurse or designee will complete a psychotropic medication review in ECP (electronic charting system) for all PRN psychotropics." On 10/17/2024 at 9:00 AM, Surveyors interviewed Community Director (CD) G. CD G stated that Registered Nurse (RN) H was in charge of all psychotropic medication reviews. CD G stated RN H ran and reviewed those reports but was rarely on site. On 10/25/2024 at 10:30 AM, Surveyor interviewed COO A. COO A stated RN H visited the facility 1 to 2 times per month and part of his/her role was to do psychotropic medication reviews. COO A confirmed scheduled psychotropic medication reviews had not been done by RN H since May 2024 and indicated s/he would look further into the concern. The provider did not monitor at least monthly for the inappropriate use of PRN psychotropic medication for Resident 6.	N 408		
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,	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 452	Continued From page 41 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 under sanitary conditions for the prevention of food borne illnesses. The temperature of the refrigerator was not at or below 40 degrees Fahrenheit. Refrigerated and frozen foods were not labeled and dated consistently. This had the potential to affect 28 of 28 residents residing in the facility. Findings include: The provider is licensed to care for 33 residents in the client groups irreversible dementia/Alzheimer's disease and advanced aged. On 09/25/2024 at approximately 6:15 AM, Surveyor observed the following in the first-floor kitchen:	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 452	Continued From page 42 -The freezer contained 2 packages of spinach wraps with an expiration date of 08/08/2024. -The refrigerator contained multiple food products and leftovers not dated and unlabeled, including salsa, pickles, ketchup, salad dressings, sour cream, taco sauce, pie, and applesauce. -The pantry contained multiple food products not dated, including peanut butter, cereal, ice cream cones. On 09/25/2024 at approximately 7:15 AM, Surveyor observed the following in the third-floor kitchen and medication cart: -The medication cart contained an opened container of applesauce not dated on top. -The freezer contained multiple food products not dated, including an opened package of cookie dough, ice cream, and bread. -The freezer did not contain a thermometer. -The refrigerator contained multiple opened food products not dated, including pickles, jelly, salad dressings, condiments, and applesauce. -The refrigerator contained food leftovers not dated or unlabeled, including a pan of dessert and 2 large bowls of food. -The refrigerator thermometer read 46 degrees Fahrenheit. -The pantry contained multiple food products not dated, including taco sauce, peanut butter, honey, and pretzels. On 09/25/2024 at approximately 7:30 AM, Surveyor interviewed Caregiver O. Caregiver O stated the expectation was to throw out leftover food after 3 days and all food should be dated and labeled. On 09/25/2024 at approximately 7:45 AM, Surveyor observed the following in the second-floor kitchen:	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 452	Continued From page 43 -The refrigerator contained applesauce, pie, sour cream, and juice, not dated or labeled. -The refrigerator had no thermometer. -The refrigerator had food grime on the shelves. 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, ready 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 10/17/2024 at 9:00 AM, Surveyors interviewed Community Director (CD) G. CD G confirmed the expectation was for staff to throw leftover food out after 3 days and this was the overnight shift task. Overnight shift was also expected to clean the floor refrigerators and freezers. CD G stated staff were expected to have an open date on all food kept on the floors and the kitchen was expected to put a prepared date on food sent up to the floors. CD G indicated refrigerator and freezer temperatures were not checked or documented on the floors. On 10/25/2024 at 10:30 AM, Surveyor interviewed Chief Operating Officer (COO) A. COO A stated staff were responsible for general cleaning of the floor kitchens. COO A stated the floor supervisors were responsible for the	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012212	A. BUILDING: _____ B. WING _____	R-C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE (THE)	225 E 4TH AVE STANLEY, WI 54768

(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 452	Continued From page 44 refrigerator and freezer temperature checks and logging them.	N 452		