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	0012702	A. BUILDING: _____ B. WING _____	R-C 06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMETOWN SENIOR LIVING	1015 CREST VIEW DR HUDSON, WI 54016

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{M 000}	INITIAL COMMENTS On 06/21/2023, Surveyor conducted a complaint investigation and verification visit at Hometown Senior Living. Data was collected through 06/27/2023. The complaint was substantiated. Five violations were identified. Two of 5 violations were repeat deficiencies. See Statement of Deficiency (SOD) E3GH11, dated 05/18/2022. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 4	{M 000}		
{M 232}	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 4 staff reviewed were screened for communicable disease. This is a repeat deficiency. See Statement of	{M 232}		

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

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{M 232}	Continued From page 1 Deficiency (SOD) E3GH11, dated 05/18/2022. Findings include: On 08/03/2022, the Department issued a notice and order with SOD E3GH11 that read, "AS SOON AS PRACTICABLE AND WITHOUT DELAY, within 45 days of receipt of this notice, the licensee shall achieve and maintain substantial compliance with all requirements." On 06/21/2023 and 06/27/2023, Surveyor reviewed staff records. None of the records included evidence that staff were screened for communicable diseases other than tuberculosis. The following files were reviewed: - House Manager (HM) A, hired on 07/02/2021 - Caregiver B, hired on 12/01/2020 - Caregiver C, hired on 03/23/2022 - Caregiver D, hired on 01/27/2022 On 06/27/2023 at 2:00 PM, Surveyor interviewed Vice President (VP) E. VP E stated new employees were screened and tested for TB; the provider did not screen for other communicable diseases.	{M 232}		
M 342	88.05(4)(d)1 FIRE SAFETY EVACUATION PLAN The licensee shall have a written plan for the immediate and safe evacuation of all occupants of the home in the event of a fire. The plan shall identify an external meeting place. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not have a plan to ensure safe evacuation of 3 of 4 residents in the	M 342		

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M 342	Continued From page 2 event of a fire. Findings include: The provider is licensed to care for 4 residents in the client groups physically disabled and advanced aged. On 06/21/2023 at approximately 9:45 AM, Surveyor interviewed Caregiver C. Caregiver C stated there were 4 residents living at the home and 3 of them required full transfer assistance via ceiling lift. On 06/21/2023 and 06/27/2023, Surveyor reviewed resident records. The following residents were documented as point-of-rescue or rescue-in-place on their Resident Evacuation Assessments (Department of Health Services form F-62373): - Resident 1, admitted on 04/01/2021 - Resident 2, admitted on 10/26/2021 - Resident 3, admitted on 12/18/2013 On 06/27/2023 at 2:00 PM, Surveyor asked Vice President (VP) E and Director of Operations (DO) F to discuss their evacuation plan. DO F stated staff would shut the doors of residents who were designated as rescue-in-place. DO F said staff would evacuate who they could from the home, but the 3 residents requiring ceiling lift were considered rescue-in-place if they were in bed. Surveyor asked if the provider received Department approval for point-of-rescue. VP E and DO F stated they were not aware they needed approval. Surveyor provided technical assistance on the need for a plan to safely evacuate all residents from the home in an emergency. VP E stated they would re-evaluate their evacuation procedures.	M 342		

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M 438	88.07(2)(b) SERVICES DIRECTED TO GOALS Services shall be directed to the goal of assisting, teaching and supporting the resident to promote his or her health, well-being, self-esteem, independence and quality of life. The services shall include but are not limited to: This Rule is not met as evidenced by: Based on interview, observation, and record review, the provider did not ensure Resident 1 received services that supported his/her health, well-being, self-esteem, independence, and quality of life. Resident 1 did not receive transfer assistance, repositioning, or incontinence care to meet his/her needs. Findings include: The provider is licensed to care for 4 residents in the client groups physically disabled and advanced aged. On 05/22/2023, the Department received a complaint regarding the provider's services. On 06/21/2023 at approximately 9:45 AM, Surveyor interviewed Caregiver C. Caregiver C stated the provider scheduled 1 staff per shift, but there were 2 staff scheduled from 9:30 to 2:30 on shower days (Tuesday and Friday). Caregiver C stated Resident 1 required full assist with all activities of daily living except feeding. Resident 1 used an electric wheelchair for mobility, required transfer assistance via mechanical ceiling lift, and repositioning every 2 hours to prevent skin breakdown. Resident 1 had a catheter and	M 438		

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colostomy bag; however, s/he still required regular incontinent brief changes due to bypassing.

At 10:21 AM, Surveyor interviewed Resident 1. Resident 1 stated his/her power of attorney (POA) felt s/he needed to find a place that could provide 2-person transfers and therapy. Surveyor asked if Resident 1 wanted that and Resident 1 stated, "I'd feel more comfortable with 2-assist on the Hoyer (mechanical lift)." Resident 1 also said House Manager (HM) A could not turn Resident 1 so s/he did not get turned, repositioned, or changed when HM A was working. Resident 1 said HM A worked fulltime on second shift.

At 10:40 AM, Surveyor observed Caregiver C reposition and change Resident 1's incontinence brief. During the observation, Resident 1 stated, "[HM A] prefers 1st shift puts me back in bed... if I wanted to get out of bed on 2nd shift, I couldn't." Surveyor asked Caregiver C if s/he was directed to put Resident 1 back in bed before HM A started his/her shift. Caregiver C stated s/he was never directed to do this by HM A but Resident 1 told Caregiver C that HM A wanted him/her in bed before s/he started his/her shift. Caregiver C stated s/he noticed HM A was visibly frustrated when Resident 1 was not in bed at the start of his/her shift. Surveyor asked Resident 1 if s/he preferred to be in bed and Resident 1 replied, "No. I like the variation."

Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 04/01/2021 with diagnoses that included multiple sclerosis, paraplegia, major depressive disorder, muscle weakness, neuromuscular dysfunction of bladder, and overactive bladder. Resident 1's service plan (dated 02/15/2023) indicated Resident 1 required

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transfer assistance via mechanical ceiling lift and repositioning every 2 hours.

Resident 1's record included the following notes:
- 10/20/2022: "Care Conference...Concerns/Issues: ... Bed mobility w/ [with] some staff due to staff height."
- 05/09/2023: "OT [occupational therapy] PT [physical therapy] start of care today at 1130 hours for resident."
- 05/16/2023: "Care conference with [managed care organization (MCO)], [home health services] RN, [provider] RNs and Director...Noted 2 person assist recommended with transfers. Noted ceiling lift rated for one. Noted no complications with repositioning until resident experiences bypassing. Noted care needs being met, but concerns with additional staff wanted. Noted with [sic] licensee will always have a 1:4 ratio."

On 06/26/2023 at 3:10 PM, Surveyor interviewed POA I. POA I stated Resident 1 needed 2-assist "for a while now." POA I said Resident 1's PT and OT assessed him/her and recommended 2-assist with transfers. POA I said this was discussed at a recent care conference and the provider said they would not provide 2 staff per shift. POA I stated s/he asked during the staff meeting if any staff had voiced concerns about being able to transfer and reposition Resident 1 independently, and HM A replied that Resident 1 was difficult to reposition for some staff. POA I stated HM A discussed not being able to roll Resident 1 and Resident 1 reported an overnight staff had physical restrictions that prevented him/her from repositioning Resident 1.

POA I also voiced concern that the provider's mechanical lift was not reliable, resulting in residents not being transferred out of bed for

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days at a time.

On 06/26/2023 at 3:37 PM, Surveyor interviewed Resident 1's registered nurse (RN) case manager, RN K. RN K stated Resident 1's PT and OT assessed Resident 1 to need 2-assist with transfers and cares. RN K stated their documentation identified Resident 1 as "full cares" or "full assist," which meant 2-person assist. RN K said they discussed this with the provider during the last care conference and the provider stated their license did not require them to provide 2 staff. RN K stated Resident 1's homecare services began in July 2021, approximately 3 months after admission to the facility. Since this time, Resident 1 experienced a "marked decline in physical ability and mental status." RN K stated s/he recommended Resident 1 move to a skilled nursing facility where s/he could receive skilled care and therapy.

On 06/27/2023 at 2:00 PM, Surveyor interviewed Vice President (VP) E, Director of Operation (DO) F, RN G and RN H. Surveyor asked them about the October care conference note referenced above. RN G stated there was a staff member who was having difficulty repositioning Resident 1. RN G could not recall who the staff member was or what they did to remedy the situation. RN G guessed they either retrained the staff member or asked the staff member directly about the concern and found there was no issue. Surveyor asked if this was the first staff that reported concerns about repositioning Resident 1 independently. DO F said Caregiver B had issues rolling Resident 1 so s/he directed HM A to retrain Caregiver B. DO F said s/he had not heard of any concerns so s/he assumed the issue was resolved. RN G said s/he tried following up with Caregiver B but had not been able to connect

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M 438	Continued From page 7 with him/her. DO F and RN G denied knowledge of HM A's difficulty in repositioning Resident 1. DO F and RN G stated HM A quit unexpectedly after the survey started. Surveyor asked them to discuss the May care conference. RN H stated Resident 1's PT/OT recommended 2-assist due to Resident 1's recent decline. VP E stated they were not able to provide 2 staff per shift. RN G said their policy allowed 1 staff to operate the mechanical lift. Surveyor provided technical assistance on the need to meet individual resident needs even if this meant needing to provide additional staff. All managers stated this made sense and DO F stated Resident 1's MCO was looking into alternative placement. Cross reference: M0574 DHS 88.10(3)(n)1 Freedom From Seclusion And Restraints	M 438		
{M 464}	88.07(3)(d) MEDICATION- WRITTEN ORDER Before the licensee or service provider dispenses or administers a prescription medication to a resident, the licensee shall obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. The licensee shall keep the written order in the resident's file. This Rule is not met as evidenced by:	{M 464}		

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{M 464}	Continued From page 8	{M 464}		

Based on record review and interview, the provider did not ensure 1 of 1 resident record reviewed (Resident 1) included a written order from the prescribing physician indicating who could administer medications.

This is a repeat deficiency. See Statement of Deficiency (SOD) E3GH11, dated 05/18/2022.

Findings include:

On 08/03/2022, the Department issued a notice and order with SOD E3GH11 that read, "AS SOON AS PRACTICABLE AND WITHOUT DELAY, within 45 days of receipt of this notice, the licensee shall achieve and maintain substantial compliance with all requirements."

On 06/21/2023 and 06/272023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 04/01/2021 with diagnoses that included multiple sclerosis and paraplegia. Resident 1's medication record indicated s/he was prescribed approximately 30 medications, 15 of which were administered daily. Resident 1's record did not include a written order from Resident 1's physician indicating who should administer his/her medications.

On 06/27/2023, Surveyor sent an email to Vice President (VP) E requesting Resident 1's written authorization to administer medications.

At 2:00 PM, Surveyor interviewed the provider's management team which included VP E, Director of Operations (DO) F, Registered Nurse (RN) G, and RN H. Surveyor asked if the provider obtained written authorizations from prescribing physicians prior to administering resident medications. The team discussed the

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{M 464}	Continued From page 9 requirement and stated they believed it was included on their physician plan of care form which they would send to Surveyor by the end of the day. At 5:00 PM, Surveyor received an email from VP E with Resident 1's written authorization to administer medications. The order was signed and dated 06/27/2023.	{M 464}		
M 574	88.10(3)(n)1 Freedom From Seclusion and Restraints Except as provided in subd. 2, to be free from seclusion and from all physical and chemical restraints, including the use of an as-necessary (PRN) order for controlling acute, episodic behavior. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 3 of 4 residents were free from seclusion from 04/22/2023 through 04/26/2023 when the provider's mechanical lift broke, and alternative transfer assistance was not provided. Findings include: The provider is licensed to care for 4 residents in the client groups physically disabled and advanced aged. On 05/22/2023, the Department received a complaint regarding the provider's mechanical lift and services.	M 574		

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M 574	Continued From page 10 On 06/21/2023 at approximately 9:45 AM, Surveyor interviewed Caregiver C. Caregiver C stated there were 4 residents living at the home and 3 of them required full transfer assistance via a mechanical ceiling lift. Caregiver C showed Surveyor the provider's mechanical lift which could be attached to the ceiling tracks in each of the resident rooms. Caregiver C stated the lift was moved from room to room as needed. Caregiver C said the lift broke during a Saturday shift about 2 months prior and a replacement was not obtained until s/he reported it to the nurse the following week. Caregiver C estimated the provider was without a lift for 4 days. Surveyor asked how they transferred residents during this time and Caregiver C stated, "We didn't...It was really hard on [Resident 2] and [Resident 3]." Caregiver C stated Resident 2's behaviors typically stemmed from being left in his/her room, and during the time the lift was out, Resident 2 yelled a lot. Caregiver C stated Resident 2 had wounds on his/her back and coccyx prior to and during the time the lift was broken. Caregiver C said, "[Resident 3] was really expressive...said things like, 'This isn't fair' and 'This needs to get fixed.'" At 10:05 AM, Surveyor interviewed Resident 3. Resident 3 was in an electric wheelchair and was working in his/her woodshop. S/he showed Surveyor the various figurines s/he carved and painted. Surveyor asked Resident 3 about the incident noted above. Resident 3 stated the lift broke and s/he was "stuck in bed for several days...I was bummed. I had work to do. Things I needed to get done." Resident 3 said this was the 2nd time in the past year when s/he was stuck for a couple days because the mechanical lift broke. Resident 3 said there were also other times when s/he was stuck in his/her chair when s/he wanted	M 574		

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to go to bed because the lift did not have enough charge to complete the transfer. Resident 3 said, "They should have a 2nd [lift] on hand so we aren't stuck."

At 10:21 AM, Surveyor asked Resident 1 about the mechanical lift incident. Resident 1 stated, "Oh. I just took it with a grain of salt. Those things happen." Surveyor asked if Resident 1 preferred to be in bed most of the day and Resident 1 stated, "No. I like the variation."

Surveyor reviewed Resident 2's record. Resident 2 was admitted on 10/26/2021. His/her service plan (dated 01/16/2023) indicated s/he had diagnoses that included cerebral palsy, transient paralysis, cognitive deficit, history of poliomyelitis, and pressure ulcer of buttock: coccyx breakdown. The service plan indicated Resident 2 required total transfer assistance via ceiling lift and toileting assistance every 2 to 4 hours. The plan read, "Assist with transferring to commode every two to four hours and per request. Unlicensed assistive personnel to physically assist resident to use toilet, and/or change adult undergarments and provide pericare as needed. May require transfer assistance.. [sic] Community to provide assistance to ensure and maintain independence where possible, dignity and hygiene."

On 06/26/2023 at 3:10 PM, Surveyor interviewed Resident 1's activated healthcare directive, Power of Attorney (POA) I. POA I stated s/he visited the facility often and believed the provider's mechanical lift was not reliable. POA I stated there were times that the lift would only hold enough charge to complete 1 transfer, so if 2 residents needed to use it, one would need to wait for it to charge. POA I stated the lift recently broke and the provider did not have a way to

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M 574	Continued From page 12 transfer residents out of bed for multiple days. On 06/27/2023 at 2:00 PM, Surveyor interviewed Director of Operations (DO) F and RN G. DO F stated the provider's mechanical lift was out for 2 days. Surveyor asked when this occurred and how they transferred residents during this time. DO F stated, "They didn't get up...it happened over a weekend." They were unable to locate documentation of the incident but RN G stated s/he was notified of the situation on Wednesday 04/26/2023 via text message and s/he had a new lift delivered to the facility within 3 hours. DO F stated again that the lift broke over the weekend which meant the provider was without a lift for more than 2 days.	M 574		