STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017223	A. BUILDING: _____ B. WING _____	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM INC ELMWOOD	6866 ELMWOOD DR MIDDLETON, WI 53562

(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
M 000	INITIAL COMMENTS On 03/27/2024, with information gathered through 03/29/2024, Surveyor conducted a standard licensure survey at REM Inc. Elmwood. Four deficiencies were identified. One of the 4 deficiencies was a repeat violations (see Statement of Deficiency (SOD) L0X911). Census: 4	M 000		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 4 resident's (Resident 1, Resident 3, and Resident 4) Individual Service Plan (ISP) were reviewed at least once every six months by the provider, the	M 424		

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
	0017223	A. BUILDING: _____ B. WING _____	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM INC ELMWOOD	6866 ELMWOOD DR MIDDLETON, WI 53562

(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
M 424	Continued From page 1 resident and/or resident's guardian, or the placing agency. This is a repeat deficiency. See Statement of Deficiency (SOD) L0X911, dated 11/29/2021. Findings include: On 03/27/2024, Surveyor reviewed Resident 1's record. Resident 1 moved into the home on 03/18/2014 and had a guardian. Resident 1's record contained an ISP dated 07/17/2023. Resident 1's record was due to be reviewed in 01/2024. Resident 3 moved into the home on 08/02/1995 and had Guardian C and managed care organization (MCO) Care Manager (CM) D. Resident 3's record contained an ISP dated 10/08/2023 that was not signed by Guardian C or CM D. Resident 4 moved into the home on 03/01/2006 and had MCO CM E. Resident 4's record contained an ISP dated 10/23/2003 that was not signed by CM E. On 03/29/2024 at 8:57 AM, Surveyor emailed Area Director A and Program Director B and requested clarification. As of 03/29/2024 at 5:00 PM, Surveyor did not receive a response.	M 424		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS	M 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017223	A. BUILDING: _____ B. WING _____	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM INC ELMWOOD	6866 ELMWOOD DR MIDDLETON, WI 53562

(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
M 458	Continued From page 2 Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not securely store medications or store medications as specified by the pharmacist. Resident 1 had a bottle of expired Earwax removal solution available in his/her medication bin. Resident 2 had bottles of expired Fluticasone (nasal spray) available in his/her medication bin. Findings include: On 03/27/2024, at approximately 10:15 AM, Surveyor reviewed Resident 1's and Resident 2's medications. Example 1: Resident 1 There was a bin in the med closet labeled [Resident 1]. The bin contained the following bottles of Earwax removal solution: Rx# (prescription number) 1368942/0. Fill Date: 12.12/2022. Rx Expire Date: 12/12/2023.	M 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017223	A. BUILDING: _____ B. WING _____	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM INC ELMWOOD	6866 ELMWOOD DR MIDDLETON, WI 53562

(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
M 458	Continued From page 3 On 03/28/2024, Surveyor reviewed Resident 1's March 2024 Medication Administration Record which documented: "Rx # 06886057 - Carbamide Peroxide 6.5% drops - Instill 5 to 10 drops into each ear 2 times daily for 3 days. May repeat as needed. Start Date: 02/29/2024. End Date: 03/04/2024." Example 2: Resident 2 There was a bin in the med closet labeled [Resident 2]. The bin contained the following bottles of Fluticasone: Rx# 1303303/3. Fill Date: 10/14/2022. Rx Expire Date: 06/29/2023. Rx# 1357584/9. Fill Date: 08/11/2023. Rx Expire Date: 11/14/2023. On 03/28/2024, Surveyor reviewed Resident 2's March 2024 Medication Administration Record which documented: "Fluticasone Prop 50 MCG (microgram) Spray - Instill 2 sprays into each nostril daily for allergic rhinitis). Rx # 06886100. Start Date: 02/29/2024." On 03/29/2024 at 8:57 AM, Surveyor emailed Area Director A and Program Director B and requested an explanation as to why expired medications were available in the resident's medication bins. Area Director A explained that the provider switched pharmacies and "it was a process to get everyone's medications switched over correctly. The medications will be reviewed to ensure accuracy."	M 458		
M 462	88.07(3)(c) MEDICATION ASSISTANCE If the licensee or service provider	M 462		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017223	A. BUILDING: _____ B. WING _____	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM INC ELMWOOD	6866 ELMWOOD DR MIDDLETON, WI 53562

(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
M 462	Continued From page 4 assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident received prescribed medications in the proper dosage. Resident 2 did not receive his/her Omeprazole (medication acid reflux) and Melatonin (sleep aid) as prescribed. Findings include: On 03/27/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the home, 07/01/1985, with diagnoses including developmental delay and acid reflux. Resident 2's March 2024 Medication Administration Record documented the following: Omeprazole 20 MG (milligram) cap - Take 1 capsule by mouth 2 times daily for reflux. Scheduled at 8:00 AM and 8:00 PM. Start Date: 01/23/2023. Medication was documented as "OOS (Medication Unavailable - out of stock)": 8:00 AM - 03/02/2024 through 03/06/2024	M 462		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017223	A. BUILDING: _____ B. WING _____	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM INC ELMWOOD	6866 ELMWOOD DR MIDDLETON, WI 53562

(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
M 462	Continued From page 5 8:00 PM - 03/01/2024 through 03/05/2024 Melatonin 3 MG Tab - Take 1 Tablet by mouth daily at 7PM. Start Date: 01/19/2023. Medication was documented as "OOS" on 03/01, 03/02 and 03/05. On 03/29/2024 at 8:57 AM, Surveyor emailed Area Director A and Program Director B and requested an explanation as to why Resident 2's medications were not available. As of 03/29/2024 at 5:00 PM, Surveyor did not receive a response.	M 462		
M 482	88.09(1)(a) RESIDENT RECORDS The licensee shall maintain a record for each resident. Resident records shall be maintained in a secure location within the home to prevent unauthorized access. This Rule is not met as evidenced by: Based on record review and interview, licensee did not maintain complete records for 4 of 4 residents. Residents' current evacuation assessment were not maintained in the home. Findings include: On 03/27/2024, Surveyor reviewed Resident 1's, Resident 2's, Resident 3's and Resident 4's record. Resident 1 was admitted to the home on	M 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017223	A. BUILDING: _____ B. WING _____	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM INC ELMWOOD	6866 ELMWOOD DR MIDDLETON, WI 53562

(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
M 482	Continued From page 6 03/18/2014. Resident 1's available evacuation assessment was dated 02/03/2022. Resident 2 was admitted to the home on 07/01/1985. Resident 2's available evacuation assessment was dated 02/03/2022. Resident 3 was admitted to the home on 08/02/1995. Resident 3's available evacuation assessment was dated 02/03/2022. Resident 4 was admitted to the home on 03/01/2006. Resident 4's available evacuation assessment was dated 02/03/2022. On 03/27/2024, at approximately 3:25 PM, Surveyor interviewed Area Director A. Surveyor began to explain that evacuation assessments need to be completed annually. Area Director A stated, "I am sure they have been completed." Area Director A reviewed the electronic computer program and stated the evacuation assessments had been completed when the resident's Individual Service Plans were updated. Surveyor asked if staff had access to this current documentation. Area Director A stated s/he was not sure what documentation staff had access to on the electronic computer system. Area Director A stated s/he would update the resident binders in the home with the current assessments.	M 482		