STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019745	A. BUILDING: _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING BLOOMER I	406 PRIDDY ST BLOOMER, WI 54724

(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 03/20/2024, Surveyor conducted a licensure survey, self-report review, and 2 complaint investigation at VitaCare Living Bloomer I. Data collection continued through 04/17/2024. One of 2 complaints was substantiated. Eighteen deficiencies were identified. Census: 13	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. 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 ensure Caregiver C was screened by a registered nurse, physician, physician assistant, or clinical nurse practitioner, for communicable disease, including tuberculosis (TB), according to the Centers for Disease Control and Prevention (CDC) standards.	N 220		

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

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N 220	Continued From page 1 Findings include: The Department of Health Services publication, Tuberculosis Screening and Testing: Health Care Personnel (HCP) and Caregivers (including assisted living staff), states: "Perform baseline testing for all HCP and caregivers without documented evidence of prior LTBI [latent tuberculosis] or TB disease... IGRA [blood test] or TST [tuberculin skin test] may be performed; IGRA is preferred... - If testing is positive, obtain chest x-ray and refer HCP or caregiver to provider for additional workup for TB disease. - In the absence of newly identified risks or symptoms, previous documented negative IGRA or TST results (within 12 months) may be used. - If TST is used as the baseline testing, 2-step testing is recommended for HCP and caregivers who have not had TST testing previously or have only had one negative TST test greater than 12 months ago. If 2 or more TST tests have been previously performed, all results are negative, and documentation of results is available, a one-step TST may be performed before hire." (Retrieved 04/09/2024 from https://dhs.wisconsin.gov/publications/p02382.pdf) On 03/20/2024, at approximately 2:00 PM, Surveyor reviewed 5 employee records. Caregiver C was hired on 01/18/2024. His/her record included a communicable health screen completed on 01/19/2024. On 03/28/2024 at 1:45 PM, Surveyor requested via email Caregiver C's TB test. On 04/01/2024 at 2:25 PM, Surveyor received an	N 220		

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N 220	Continued From page 2 email from RN A that did not include a TB test for Caregiver C. On 04/16/2024 at 3:30 PM, Surveyor interviewed Registered Nurse (RN) A, Director B, and Regional Operations Director (ROD) I. RN A stated Caregiver C's whole record had been misplaced. RN A stated s/he would have Director B speak with Caregiver C and get an extra copy. On 04/17/2024 at 8:39 AM, Surveyor received an email from RN A that read, in part, "We unfortunately cannot locate the ... TB test...again, this is discouraging for me but we have exhausted all our resources to find this and unsure where this is located. - per [Director B], [Caregiver C] is reaching out to Marshfield Clinic to obtain this, we will do our best to get that to you before 12pm [sic] today." Surveyor did not receive a TB skin test for Caregiver C.	N 220		
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		

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N 302	Continued From page 3	N 302		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 2 residents sampled (Resident 2 and Resident 3) had a health screen, including tuberculosis (TB) testing, in accordance with the Centers for Disease Control and Prevention (CDC) standards.

Findings include:

The provider is licensed to serve up to 17 residents in the client group advanced aged. The current provider took over a previous provider on 09/13/2023.

According to the Wisconsin Tuberculosis Program (publication P-02382A) Tuberculosis Screening and Testing: Residents of Care Facilities (retrieved from: https://www.dhs.wisconsin.gov/publications), screening for the presence of communicable disease, including TB, includes the following three steps:
1) TB risk assessment
2) Symptom evaluation
3) TB testing..."Perform baseline testing for all residents without documented evidence of prior [latent TB infection] or TB disease."

On 03/20/2024, Surveyor reviewed the records for Resident 2 and Resident 3.

Resident 2 was admitted to the facility on 12/15/2023. Resident 2's record did not contain documented evidence of a health screen.

Resident 3 was admitted to the facility on

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N 302	Continued From page 4 12/18/2023. Resident 3's record contained a TB skin test completed on 07/05/2023; over 90 days prior to admission to the new provider. On 03/28/2024 at 1:45 PM, Surveyor requested Resident 2's health screen via email . On 04/01/2024 at 2:25 PM, Surveyor received an email from Registered Nurse (RN) A that read, in part, "unable to locate document." On 04/16/2024 at 3:30 PM, Surveyor interviewed RN A, Director B, and Regional Operations Director (ROD) I. RN A stated s/he was not sure what happened to Resident 2's health screening. On 04/17/2024 at 8:39 AM, Surveyor received an email from RN A that read, in part, "Unable to find/locate the health screen for [Resident 3]."	N 302		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary	N 310		

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N 310	Continued From page 5	N 310		

discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not obtain a signed and dated admission agreement for 3 of 4 resident records reviewed (Resident 1, Resident 3, and Resident 4).

Findings include:

The provider is licensed to serve up to 17 residents in the client group advanced aged. The provider was licensed effective 09/13/2023, after a change of ownership.

On 03/20/2024, Surveyor reviewed resident records. The following was identified:

Resident 1
-Admission date under previous provider:

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N 310	Continued From page 6 10/12/2018 -Admission date with new provider: 09/13/2023 -There was no evidence Resident 1 had completed an admission agreement with the current provider. Resident 3 -Admission date with new provider: 12/18/2023 -There was no evidence Resident 3 had completed an admission agreement with the current provider. Resident 4 -Admission date with previous provider: 02/17/2018 -Admission date with new provider: 09/13/2023 -There was no evidence Resident 4 had completed an admission agreement with the current provider. On 03/28/2024 at 1:45 PM, Surveyor requested, via email, Resident 1's, Resident 3's, and Resident 4's signed and dated admission agreements. On 04/01/2024 at 2:25 PM, Surveyor received an email from RN A that read, in part, "unable to provide proof of signed agreement (for Resident 3) but it [sic] part of our policies and procedure during admission to review these through the Resident Handbook." RN A's response for Resident 1 and Resident 4 read, in part, "unable to locate document; has been completed currently." On 04/16/2024 at 3:30 PM, Surveyor interviewed RN A, Director B, and Regional Operations Director (ROD) I. RN A stated all directors in their company had the directive to update the admission agreements for all residents with the	N 310		

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N 310	Continued From page 7 change in ownership. RN A stated they could not find the admission agreements for Resident 1, Resident 3, and Resident 4.	N 310		
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. 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 1 of 4 residents reviewed (Resident 3). Findings include: The provider is licensed to serve up to 17 residents in the client group advanced aged. The provider was licensed effective 09/13/2023 after a change of ownership. On 03/20/2024 at approximately 2:00 PM, Surveyor reviewed the record for Resident 3.	N 343		

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N 343	Continued From page 8 Resident 3 was admitted to the facility on 12/18/2023. Surveyor was unable to locate documentation indicating resident rights, grievance procedures and house rules were explained to or signed by Resident 3 upon admission. On 03/28/2024 at 1:45 PM, Surveyor requested, via email, Resident 3's documentation indicating resident rights, grievance procedures and house rules were explained to or signed by Resident 3 upon admission. On 04/01/2024 at 2:25 PM, Surveyor received an email from RN A that read, in part, "Unable to provide proof of signed agreement but it [sic] part of our policies and procedure during admission to review these through the Resident Handbook." On 04/16/2024 at 3:30 PM, Surveyor interviewed RN A, Director B, and Regional Operations Director (ROD) I. RN A stated all directors in their company had the directive to update the admission agreements for all residents affected by the change in ownership. RN A stated they could not find the admission agreements for Resident 1, Resident 3, and Resident 4, that contained the signed statement acknowledging the provider explained resident rights, grievance procedure, and house rules.	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	N 352		

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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 2 and Resident 3 received all medications in the dosages and at intervals prescribed by a practitioner.

Resident 2 had not received his/her prescribed daily gabapentin in December 2023.

Resident 3 did not receive multiple medications as prescribed in December 2023 through February 2024.

Findings include:

The provider is licensed to serve up to 17 residents in the client group advanced aged.

On 03/20/2024, Surveyor reviewed the records for Resident 2 and Resident 3.

Resident 2

Resident 2 was admitted to the facility on 12/15/2023. Resident 2 had diagnoses that included adult failure to thrive, anemia, diabetes mellitus type 2 with diabetic nephropathy, chronic kidney disease, ischemic heart chronic disease, and morbid obesity. Resident 2 had an activated power of attorney (POA) and had medications managed by the provider.

The December 2023 medication administration record (MAR) indicated Resident 2 was taking gabapentin 300 milligrams (mg) 1 capsule 3 times per day. Staff notes on the back of the MAR

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indicated gabapentin was "out of stock" in the medication cart for the following dates and times:

12/20/2023 - 12:00 PM
12/21/2023 - 8:00 AM and 12:00 PM.

Resident 3

Resident 3 was admitted to the facility on 12/18/2023. Resident 3 had diagnoses that included type 2 diabetes mellitus, hemiplegia and hemiparesis following a cerebral infarction affecting left non-dominant side, morbid obesity, and fracture of left femur. Resident 3 had an activated POA and had medications managed by the provider.

Staff notes on the back of the December 2023 through February 2024 MAR indicated the following medications were "out of stock" in the medication cart for the following dates and times:

certavite senior - take 1 tablet once daily (scheduled for 8:00 AM)
12/20/2023
12/25/2023
12/28/2023
12/29/2023
12/30/2023
12/31/2023

coenzyme Q-10 100 mg - take 1 capsule once daily (scheduled for 8:00 AM)
12/20/2023
12/21/2023
12/22/2023
12/25/2023
12/28/2023
12/29/2023
12/30/2023

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N 352	Continued From page 11 12/31/2023 01/01/2024 01/02/2024 01/03/2024 01/06/2024 01/10/2024 01/11/2024 01/13/2024 01/15/2024 01/16/2024 01/17/2024 01/19/2024 01/20/2024 01/21/2024 02/02/2024 cyclobenzaprine 5 mg - take 1 tablet once daily (scheduled at 8:00 AM) 01/22/2024 01/23/2024 01/24/2024 01/25/2024 01/26/2024 01/27/2024 01/29/2024 01/31/2024 02/05/2024 02/06/2024 02/07/2024 02/09/2024 02/10/2024 02/12/2024 02/14/2024 02/15/2024 02/18/2024 melatonin 5 mg - take 1 tablet once daily (scheduled at 8:00 PM) 12/19/2023 12/20/2023	N 352		

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N 352	Continued From page 12 12/21/2023 12/22/2023 12/23/2023 12/24/2023 12/27/2023 12/28/2023 12/29/2023 12/30/2023 12/31/2023 01/02/2024 01/03/2024 01/05/2024 01/06/2024 01/07/2024 01/08/2024 01/09/2024 01/11/2024 01/12/2024 01/14/2024 01/16/2024 trazodone 50 mg - take 1 tablet once daily (scheduled at 8:00 PM) 01/24/2024 01/26/2024 01/27/2024 01/28/2024 01/29/2024 01/30/2024 01/31/2024 02/01/2024 02/04/2024 02/05/2024 02/06/2024 02/07/2024 02/08/2024 02/09/2024 02/10/2024 02/11/2024 02/12/2024	N 352		

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N 352	Continued From page 13 02/13/2024 02/14/2024 02/15/2024 omeprazole 10 mg - take 1 capsule once daily (scheduled at 8:00 AM) 02/05/2024 02/06/2024 02/07/2024 02/09/2024 02/10/2024 02/13/2024 02/14/2023 02/15/2024 02/18/2024 On 04/16/2024 at 3:30 PM, Surveyor interviewed Registered Nurse (RN) A, Director B, and Regional Operations Director (ROD) I. RN A stated Resident 3's trazadone had been discontinued and s/he had to cover coenzyme Q-10 out of his/her own pocket. RN A stated the medications should have been put on hold in the electronic MAR. RN A stated Resident 3 also had multiple appointments during that time between his/her primary physician and orthopedics, with multiple medication changes. On 04/17/2024 at 8:39 AM, Surveyor received an email from RN A that read in part, "...but it was an ongoing conversation with [Resident 3's] PCP (primary physician) and MCO (managed care organization) regarding medications and obtaining and [sic] accurate and up-to-date list. Again, staff were simply hitting 'declined' instead of us putting the medication on 'hold' in RTask...but we were aware we were missing some medications that were manually transcribed into the system versus utilizing Pharmacy Connect, directly from the pharmacy."	N 352		

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N 352	Continued From page 14 The provider did not ensure Resident 2 and Resident 3 received all medications in the dosages and at intervals prescribed by a practitioner, when Resident 2 did not receive a three doses of gabapentin in December 2023 and Resident 3 did not receive multiple medications as prescribed in December 2023 through February 2024.	N 352		
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 2 of 2 residents were evaluated within 3 days of the resident's admission for evacuation capabilities. Findings include: The provider is licensed to serve up to 17 residents in the client group advanced aged. The provider was licensed effective 09/13/2023, after	N 393		

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N 393	Continued From page 15 a change of ownership. On 03/20/2024, Surveyor requested to review records for Resident 2 and Resident 3. Resident 2 was admitted to the facility on 12/15/2023. The record did not contain evidence Resident 2 was assessed for evacuation. Resident 3 was admitted to the facility on 12/18/2023. The record contained an evacuation assessment completed on 02/01/2024, over 3 days after admission. On 03/28/2024 at 1:45 PM, Surveyor requested, via email, Resident 2's evacuation assessment. On 04/01/2024 at 2:25 PM, Surveyor received an email from Registered Nurse (RN) A that read, in part, "unable to locate document" (for Resident 2). On 04/16/2024 at 3:30 PM, Surveyor interviewed RN A, Director B, and Regional Operations Director (ROD) I. RN A stated s/he was not sure what happened to the documentation and would get it corrected.	N 393		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate 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 complete Resident 1's and	N 394		

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N 394	Continued From page 16 Resident 4's annual evacuation assessment in 2023. Findings include: The provider is licensed to serve up to 17 residents in the client group advanced aged.. The provider was licensed effective 09/13/2023, after a change of ownership. On 03/20/2024, Surveyor reviewed the records of Resident 1 and Resident 4. Resident 1 was admitted to the facility on 10/12/2018. The last evacuation assessment was dated March 2022. The record did not contain an evacuation assessment for 2023. Resident 4 was admitted to the facility on 02/17/2018. The last evacuation assessment was dated May 2022. The record did not contain an evacuation assessment for 2023. On 03/28/2024 at 1:45 PM, Surveyor requested, via email, Resident 1's and Resident 4's annual evacuation assessment for 2023. On 04/01/2024 at 2:25 PM, Surveyor received an email pertaining to Resident 1's and Resident 4's annual evacuation assessment, from Registered Nurse (RN) A that read, in part "Unable to locate document; has been completed currently." On 04/16/2024 at 3:30 PM, Surveyor interviewed RN A, Director B, and Regional Operations Director (ROD) I. RN A stated s/he was not sure what happened to the documentation and would get it corrected.	N 394		

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N 396	Continued From page 17	N 396		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure there were sufficient numbers of employees on a 24-hour basis to meet the needs of all residents. Findings include: The provider is licensed to serve up to 17 residents in the client group advanced aged. On 03/20/2024 at 9:50 AM, Surveyor interviewed Caregiver D, who had worked at the facility for 1.5 years. Caregiver D stated Resident 7 required 2-staff assistance with transfers using a Hoyer lift. Caregiver D stated staffing had been better the past 3 to 4 months since Director B started. Caregiver D stated that during some shifts, there would only be 1 staff scheduled in the facility and another staff would float between the facility and adjacent facility across the parking lot. This would occur 1 to 2 times per week. Caregiver D stated this occurred last Sunday, 03/17/2024, when s/he had to work in the facility alone with a float between the two facilities. Caregiver D stated this occurs usually when there were last minute call-ins from staff. Surveyor asked Caregiver D what would happen in an emergency when only 1 staff was in the facility. Caregiver D stated the float would come over to help and management would be called. Caregiver D stated Resident 7 would be in a wheelchair during the day. Caregiver D stated management was addressing	N 396		

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the staffing issues.

At 10:47 AM, Surveyor interviewed Housekeeper E who had worked at the facility for 2 years. Housekeeper E confirmed that at times there would be only 1 staff in the facility, with a float between the facility and adjacent facility across the parking lot.

At 12:45 PM, Surveyor interviewed Resident 7 and s/he confirmed 2 staff transfer him/her with a Hoyer lift.

At approximately 3:30 PM, Surveyor interviewed Regional Nurse (RN) A. RN A stated their typical staffing pattern was 2 staff per shift. RN A confirmed there was a resident that required 2-staff assistance in each facility. RN A confirmed that due to staff calling in last minute, they have had to schedule 1 staff in each facility with a float going between both facilities. RN A stated Resident 7 was recently changed to a Hoyer lift for transfers. Surveyor pulled out the staff schedule and asked RN A to explain it. RN A stated the staff schedule gave the times staff actually worked but it was combined for both facilities. Surveyor asked if there was a way to distinguish which staff worked on the shift for which facility. RN A stated there was not, but if there was only 3 staff scheduled for that shift, then it was 1 staff per facility with a float in between.

On 04/09/2024, Surveyor reviewed the staff schedule, Hoyer lift manual, facility lift policy and procedure, and Resident 7's record.

Resident 7 was admitted to the facility on 06/15/2023. Resident 7 had diagnoses that included hemiplegia and hemiparesis following

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cerebrovascular disease affecting right dominant side, age related osteoporosis, moderate protein calorie malnutrition, paralytic syndrome following cerebral infarction, edge compression fracture of unspecified lumbar vertebra, and muscle weakness.

The individual service plan (ISP), date unknown, indicated Resident 7 required 2-staff assistance with Hoyer lift transfers.

Resident 7 had a physician order, dated 03/06/2024, indicating only a Hoyer lift was to be used for safe transfers.

The facility lift policy and procedure read, in part, "Always use two (2) staff when transferring a patient with a mechanical lift."

The Hoyer lift manual read, in part, "strongly recommends that two caregivers take part in the lifting process."

The staff schedule, dated 03/06/2024 to 03/20/2024, indicated most of the days there was potentially only 1 staff in the facility with a float between the facility and adjacent facility for a length of time. The staff schedule did not indicate if Previous Director (PD) F was working or not on any given shift.

On 04/16/2024 at 3:30 PM, Surveyor interviewed RN A, Director B, and Regional Operations Director (ROD) I. The provider stated they understood the staffing concern and would correct the staff scheduling immediately to be in compliance.

Cross Reference N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule

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N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain an accurate staffing schedule. Findings include: The provider is licensed to serve up to 17 residents in the client group advanced aged. On 03/20/2024 at 9:50 AM, Surveyor requested the staff schedule from December 2023 to present, from Assistant Director (AD) G. At approximately 3:30 PM, Surveyor reviewed the employee schedule with Regional Nurse (RN) A. RN A stated the staff schedule provided gave the times staff actually worked but it was combined for both this facility and the adjacent facility across the parking lot. RN A stated the staffing schedules were combined and there was not a separate schedule just for this facility. Surveyor asked if there was a way to distinguish which staff worked for which facility. RN A stated there was not. RN A stated Director B and Previous Director (PD) F would not be on the schedule as they were salaried. RN A stated there was no record when they would have worked or filled in on a shift. On 04/16/2024 at 3:30 PM, Surveyor interviewed	N 399		

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N 399	Continued From page 21 RN A, Director B, and Regional Operations Director (ROD) I. ROD I indicated s/he felt this was good feedback and would work on getting the facility schedules separated and make sure Director B's time was accounted for. The provider did not maintain an accurate staffing schedule.	N 399		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.	N 431		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure health monitoring took place.

The provider did not clarify how often Resident 2's blood glucose levels should be checked as ordered upon admission.

The provider did not implement alarms once received from managed care organization (MCO).

Findings include:

On 01/03/2024, the department received a complaint alleging a resident's alarms were still in the box after his/her death from a fall.

The provider is licensed to serve up to 17 residents in the client group advanced aged.

On 03/20/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 12/15/2023 and had an activated power of attorney (POA). Resident 2 had diagnoses that included adult failure to thrive, anemia, diabetes mellitus type 2 with diabetic nephropathy, chronic kidney disease, ischemic heart chronic disease, and morbid obesity.

Example 1 - Blood Glucose Monitoring

Resident 2's admission orders, dated 12/15/2023,

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under the medication list, indicated the following:

-continue blood sugar diagnostic strips - 2 tests daily
-continue blood sugar diagnostic strips - test 3 times a day
-continue lancets - for testing 3 times daily.

A service plan, undated, indicated Resident 2 was to have his/her blood glucose checked 2 times per day.

Resident 2 's blood glucose log, dated 12/15/2023 to 12/27/2023, indicated blood glucose checks were completed 2 times daily.

On 04/16/2024 at 3:30 PM, Surveyor interviewed Regional Nurse (RN) A, Director B, and Regional Operations Director (ROD) I. RN A stated the admission paperwork should have clarified how often Resident 2's blood glucose level should have been checked daily. RN A stated s/he was not sure why this discrepancy in the admission orders was not clarified by Previous Director (PD) F with Resident 2's physician.

Example 2 - Alarms Implemented

The pre-admission assessment, undated, indicated Resident 2 had a history of falls. Resident 2 needed 1 staff assistance with transfers and needed full staff assistance with mobility. Resident 2 needed assistance with incontinent products and help during the night to toilet.

A physician order, dated 12/15/2023, read, "Chair and bed alarms always."

A fall assessment, undated, indicated Resident 2

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was a fall risk.

A service plan, undated, did not indicate Resident 2 needed a bed and/or chair alarm.

An email dated 12/15/2023 at 1:22 PM, from Previous Director (PD) F to Community Resource Coordinator (CRC) J, read, in part, "Bad news is I got orders sent with [Resident 2] to [his/her] new home with DME (durable medical equipment) requests that we don't have in house. Looks like [s/he] needs a bed and chair alarm, [family] is wanting a hospital bed, [s/he] needs a toilet seat riser etc."

An email dated 12/15/2023 at 5:41 PM, from Health and Wellness Coordinator (HWC) K to PD F, read, in part, "I will have the depends, chair/bed alarm and toilet riser ordered immediately and delivered next week ...I have yet to see any D/C (discharge) orders or DME orders from [hospital]. I was only made aware by my CRC today that [s/he] was discharging. I was at [hospital] on Wednesday and the staff I spoke with knew nothing. In the future we all have to better communication [sic] so we don't have you guys in a situation where you don't have supplies needed to take care of a member."

An incident report, dated 12/19/2023 at 12:51 AM, indicated Resident 2 had an unwitnessed fall in his/her room trying to get into bed. The incident report read, in part, "The resident rang [his/her] pendant, when staff arrived the resident was on [his/her] knees in front of [his/her] bed. Staff made multiple attempts to get the resident up, all which failed. The staff made multiple attempts to get the resident to help with the process. The resident made little to no effort to help staff get [him/her] up however, when the [Assistance

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Executive Director] arrived, [s/he] was able to help [him/her] get [Resident 2] up." Interventions implemented included a firmer box spring for his/her bed, s/he was encouraged to use his/her call button when getting up, and an order for a hospital bed was sent.

A staff note, dated 12/26/2023, indicated Resident 2 was in quarantine for the day.

An incident report, dated 12/27/2023 at 3:50 AM, indicated Resident 2 had an unwitnessed fall in his/her bathroom while going to use the toilet. Resident 2 used his/her pendant after the fall. Resident 2 fell forward into the shower and had a large hematoma on his/her left side of forehead. Resident 2 had his/her walker with him/her and was wearing grip socks. Resident 2 was sent in to be medically evaluated.

Medical notes, dated 12/27/2023, indicated Resident 2 had a significant intracranial hemorrhage and multiple medical co-morbidities with poor prognosis. The medical notes read, in part, " ...fell at [his/her] skilled nursing facility in the bathroom sustained head trauma with subdural bleed and decompensated during workup in the ED (emergency department) with subsequent admission to observation status for comfort cares but Expired [sic] soon after. Patient expired at 11:24am [sic]." The medical notes also indicated Resident 2 had a fall the previous day on 12/26/2024 and was medically evaluated in the emergency room (ER). Resident 2 was found to have hypoglycemia that improved but no traumatic injuries except bruising to his/her chest.

An email dated 01/12/2024 at 2:27 PM, from HWC K to the department read, in part, "I was in Bloomer today and picked up [Resident 2's]

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supplies from [family]. I have attached the photos that document that [his/her] toilet riser and chair/bed alarm that were delivered on 12/21 where [sic] never opened."

On 03/20/2024 at 9:50 AM, Surveyor interviewed Caregiver D. Caregiver D confirmed Resident 2 was very unsteady on his/her feet and required 1 staff assistance with transfers and mobility. Caregiver D stated Resident 2 was very independent and was not compliant with asking for help from staff.

On 03/20/2024 at 10:47 AM, Surveyor interviewed Housekeeper E, who confirmed Resident 2 did not have a bed or chair alarm during his/her time at the facility.

On 04/16/2024 at 3:30 PM, Surveyor interviewed RN A, Director B, and Regional Operations Director (ROD) I. Director B explained that some of the interventions they implemented to prevent falls for Resident 2 included staff checking on him/her frequently, requesting a hospital bed, encouraging him/her to use the call pendant, and reaching out to the managed care organization (MCO) for supplies. Director B stated Resident 2 was impulsive and never used his/her call pendant. Surveyor asked about Resident 2's fall on 12/26/2024, for which s/he was medically evaluated for in the ER. Director B stated s/he did not know about the fall. RN A stated s/he was shocked and did not know how there was no documentation related to that fall. Surveyor asked about the chair and bed alarms. RN A stated a note would have been put in the staff notes when the equipment arrived. Director B stated s/he was not sure if the chair and bed alarms were implemented once received but found it hard to believe they were not used right away, after they

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N 431	Continued From page 27 were received. The provider did not ensure health monitoring took place for Resident 2 when it was not clarified how often Resident 2' s blood glucose levels should be checked as ordered upon admission, for either 2 or 3 times daily. The provider did not implement chair and bed alarms once received from managed care organization (MCO) on 12/21/2023. On 12/27/2023, Resident 2 had an unwitnessed fall in the bathroom that caused a fatal intracranial hemorrhage. Resident 2 passed away on comfort cares the same day.	N 431		
N 441	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all employees followed hand washing procedures according to the Centers for Disease Control and Prevention (CDC) standards. Findings include: The provider is licensed to serve up to 17 residents in the client group advanced aged. On 03/20/2024, from 11:50 AM to approximately 12:35 PM, Surveyor observed staff during the noon medication pass and meal. At 11:50 AM, Caregiver D prepared for a blood glucose check for Resident 8. Surveyor observed Caregiver D place the blood glucose supplies	N 441		

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N 441	Continued From page 28	N 441		

directly on the dining room table along with the test strip that had a blood sample on it, after removing it from the glucose monitor. Caregiver D removed his/her gloves and no hand hygiene was performed.

At 11:59 AM, Caregiver D prepared oral medication for Resident 9. Caregiver D administered Resident 9's medications and did not perform hand hygiene after.

At 12:01 PM, Caregiver D prepared for a blood glucose check for Resident 4. Caregiver D put the lancet directly on the dining room table after poking Resident 4's finger. After Caregiver D administered Resident 4's insulin, no hand hygiene was performed after glove removal.

At 12:15 PM, Caregiver D went to transfer Resident 6 in his/her room with the sit-to-stand. Caregiver D applied gloves for the transfer and removed them prior to leaving Resident 6's room and pushing him/her in the wheelchair to the dining room. No hand hygiene was performed once Caregiver D returned to the dining room.

At 12:23 PM, Caregiver D prepared oral pain medication for Resident 7, with no hand hygiene performed prior and no hand hygiene performed after administration.

At 12:31 PM, Surveyor observed Caregiver H receive a dirty soup bowel from one resident and serve Resident 5 and Resident 6 their noon meal with the same gloved hands. Caregiver H then took another dirty plate from Resident 8 and did not change gloves or perform hand hygiene before continuing with meal tasks.

According to information found on

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N 441	Continued From page 29 https://www.cdc.gov/handhygiene/providers/guideline.html, "The Core Infection Prevention and Control Practices for Safe Delivery on All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC)" includes the following recommendations for hand hygiene in healthcare settings: Health care personnel should use alcohol-based hand rub or wash with soap and water for the following clinical indications: - Immediately before touching a patient - Before performing an aseptic task or... handling invasive medical devices - Before moving from work on a soiled body site to a clean body site on the same patient - After touching a patient or the patient's immediate environment - After contact with blood, body fluids, or contaminated surfaces - Immediately after glove removal." At approximately 3:30 PM, Surveyor interviewed Regional Nurse (RN) A about hand hygiene. RN A stated s/he understood the concerns and would look into more education on hand hygiene for staff.	N 441		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room.	N 481		

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N 481	Continued From page 30	N 481		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure a safe, clean, comfortable, and homelike environment.

Findings include:

The provider is licensed to serve up to 17 residents in the client group advanced aged.

On 03/20/2024, throughout the day from approximately 10:00 AM to 1:30 PM, Surveyor toured the physical environment and observed the following:

1.) In the east hallway by the medication cart and dining room, the carpet had 2 long frayed strips approximately 3 to 4 feet long posing a trip hazard.
2.) Upon entrance to Resident 4's bedroom, Surveyor identified a strong urine smell.
3.) Resident 1's room walls had numerous scrapes that removed paint in multiple areas. The end of Resident 1's bed was cracked at the footboard. The window screen had a 2-inch hole and a window shade panel was cracked. The bathroom door had 1 to 2 holes on either side. Resident 1 did not have a toilet paper holder in his/her bathroom.
4.) The oven located in the kitchen did not have a handle and had some cooked-on food. A kitchen corner cabinet was coming off its hinges and other cabinets had worn hinges. All kitchen cabinets were worn on the exterior. Multiple cabinets and drawers had food debris and grime in them. The main kitchen entrance door had a hole on the hallway side.

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N 481	Continued From page 31 At approximately 11:55 AM, Surveyor interviewed Caregiver D. Caregiver D stated the carpet had been frayed by the medication cart since s/he had worked at the facility the past 1.5 years. Caregiver D stated management had asked the new owners to replace the carpet but it had been denied. At 12:53 PM, Surveyor interviewed Resident 1. Resident 1 stated s/he had lived at the facility since 2018 and nothing had been touched up in his/her room the past 3 years. Surveyor observed Resident 1 used a motorized wheelchair. Surveyor asked Resident 1 how the wall scrapes occurred in his/her room. S/He stated the lift used with transfers would scrape the wall. Resident 1 also stated s/he would hit his/her wall by his/her bed with a long reach grabber if staff did not come promptly. Resident 1 stated his/her toilet paper holder broke a while ago and had not been fixed. At 1:25 PM, Surveyor interviewed Caregiver H working in the kitchen. Caregiver H stated s/he had been working at the facility since the beginning of 2024. Caregiver H stated his/her greatest concern was the upkeep of the building, especially the kitchen. At approximately 3:30 PM, Surveyor interviewed Regional Nurse (RN) A. RN A stated s/he understood the concerns and would let maintenance know right away. On 04/16/2024 at 3:30 PM, Surveyor interviewed RN A, Director B, and Regional Operations Director (ROD) I. RN A stated the carpet had been placed on the maintenance list. RN A stated the oven handle and Resident 1's toilet paper holder had already been fixed. RN A stated they	N 481		

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N 481	Continued From page 32 were planning to fix the cabinets when fiscally able.	N 481		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all cleaning compounds, insecticides and toxic substances were stored in a secure area. Findings include: The provider is licensed to serve up to 17 residents in the client group advanced aged. On 03/20/2024 at approximately 10:00 AM, Surveyor toured the facility and observed the following substances unsecured: Beauty Salon -nail polish remover -hair spray -fungicide and virucide -clipper disinfectant West Public Bathroom -disinfectant spray. All substance labels had warnings to keep out of reach of children. On 03/20/2024 at approximately 3:30 PM,	N 499		

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N 499	Continued From page 33 Surveyor interviewed Regional Nurse (RN) A. RN A stated s/he understood the concern with these substances needing to be secured and would immediately correct. On 04/16/2024 at 3:30 PM, Surveyor interviewed RN A, Director B, and Regional Operations Director (ROD) I. Director B confirmed the beauty salon was not kept secured. RN A commented that a resident did have a tendency to wander into the beauty salon and they would correct the issue immediately.	N 499		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct quarterly fire drills.	N 525		

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N 525	Continued From page 34 Findings include: The provider is licensed to serve up to 17 residents in the client group advanced aged. The provider received a probationary license on 09/13/2023 after a change of ownership. On 03/20/2024, Surveyor reviewed the provider's documentation of quarterly fire drills from September 2023 to March 2024. There was a documented fire drill for 10/12/2023. The fire drill did not include the individual resident evacuation times and the type of assistance each resident needed for evacuation. At approximately 3:30 PM, Surveyor interviewed Regional Nurse (RN) A. RN A stated there had been conversation to have more fire and emergency drills. On 03/28/2024 at 1:45 PM, Surveyor requested, via email, any further fire drills done from September 2023 to March 2024. On 04/01/2024 at 2:25 PM, Surveyor received an email from RN A that read, in part, "Unable to locate documentation of any additional fire drills." On 04/16/2024 at 3:30 PM, Surveyor interviewed RN A, Director B, and Regional Operations Director (ROD) I. Director B and RN A stated they were not able to find any additional fire drills done from September 2023 to March 2024. On 04/17/2024 at 8:39 AM, Surveyor received an email from RN A that read, in part, "Unable to find additional fire/emergency drills in our TELS database, and unfortunately unsure where the paper copies ended up."	N 525		

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N 525	Continued From page 35 Surveyor did not receive any additional fire drills from the provider and there was only 1 fire drill documented from September 2023 to March 2024. The fire drill on 10/12/2023 did not include the individual resident evacuation times and the type of assistance each resident needed for evacuation.	N 525		
N 534	83.48(1)(a) Smoke detection system. Except as provided under sub. (2), the CBRF shall have an interconnected smoke detection system pursuant to s. 50.035(2) Stats., and shall have an interconnected heat detection system to protect the entire CBRF so that if any detector is activated, an alarm audible throughout the building will be triggered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the smoke detectors had been tested at least every other month by staff. This had the potential to affect all the residents. Findings include: The provider is licensed to serve up to 17 residents in the client group advanced aged. The provider received a probationary license on 09/13/2023 after a change of ownership. On 03/20/2024 at 9:45 AM, Surveyor requested Regional Nurse (RN) A provide documentation that the smoke detectors were tested at least every other month since the change of ownership. At approximately 3:30 PM, Surveyor interviewed	N 534		

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N 534	Continued From page 36 Registered Nurse (RN) A. RN A stated s/he was not sure where the documentation was located for the smoke detector tests. On 03/28/2024 at 1:45 PM, Surveyor requested, via email, any smoke detector tests done from September 2023 to March 2024. On 04/01/2024 at 2:25 PM, Surveyor received an email from RN A that read, in part, "unable to locate documentation of any additional tests." Surveyor did not receive any smoke detector tests documented from September 2023 to March 2024. On 04/16/2024 at 3:30 PM, Surveyor interviewed RN A, Director B, and Regional Operations Director (ROD) I. RN A confirmed the smoke detectors were run by the provider's electricity. RN A stated staff had been testing the smoke detectors but they did not have any documentation to prove it was done. RN A stated they would add it to their electronic charting system for staff to complete moving forward.	N 534		
N 636	83.59(1)(f) Exit passageways, stairways: width maintained All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exit passageways and stairways to outside exits shall be at least 36 inches in width and maintained clear and unobstructed at all times. Exit passageways and stairways to outside exits shall be at least 32 inches in width in facilities licensed on or before the effective date	N 636		

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N 636	Continued From page 37	N 636		

of this section. In existing large facilities, the minimum corridor width shall be at least 4 feet.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure the provider had 2 exits that provided unobstructed travel to the outside. Two exits were blocked by a sit-to-stand lift and medication cart.

Findings include:

The provider is licensed to serve up to 17 residents in the client group advanced aged.

On 03/20/2024, at approximately 10:00 AM, while touring the facility, Surveyor observed the medication cart was permanently secured in the main hallway next to the dining room, obstructing the east side emergency exit pathway for travel to the outside. Residents would need to travel the exit pathway by swerving around the medication cart to get to the outside exit.

At 12:15 PM, Surveyor also observed the west side emergency exit pathway for travel outside. A sit-to-stand lift was kept in the hallway by Resident 5's and Resident 6's room, obstructing the pathway leading to an emergency exit. Residents would need to travel the exit pathway single file to get past the sit-to-stand lift.

At approximately 12:30 PM, Surveyor interviewed Caregiver D. Caregiver D confirmed the sit-to-stand was usually kept in the west side hallway and emergency exit pathway.

At approximately 3:30 PM, Surveyor interviewed Regional Nurse (RN) A. RN A stated other residents also used the sit-to-stand and they

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N 636	Continued From page 38 could find another location to store it when not in use rather than obstruct the hallway. On 04/16/2024 at 3:30 PM, Surveyor interviewed RN A, Director B, and Regional Operations Director (ROD) I. RN A stated they had immediately moved the sit-to-stand to a different location. RN A stated they would figure out where to move the medication cart so that it was not obstructing the emergency exit pathway.	N 636		
Z 005	50.065(2)(b)intro ENTITY BACKGROUND CHECK REQUIREMENTS 1. A criminal history search from the records maintained by the department of justice. 2. Every entity shall obtain all of the following with respect to a caregiver of the entity: Information that is contained in the registry under s. 146.40(4g) regarding any findings against the person. 3. Information maintained by the department of safety and professional services regarding the status of the person's credentials, if applicable. 4. Information maintained by the department regarding any final determination under s. 48.981(3)(c)5m. or, if a contested case hearing is held on such a determination, any final decision under s. 48.981(3)(c)5p. that the person has abused or neglected a child. 5. Information maintained by the department under this section regarding any denial to the person of a license, certification, certificate of approval or registration or of a continuation of a	Z 005		

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Z 005	Continued From page 39 license, certification, certificate of approval or registration to operate an entity for a reason specified in sub. (4m)(a)1. to 5. and regarding any denial to the person of employment at, a contract with or permission to reside at an entity for a reason specified in sub. (4m)(b)1. to 5. If the information obtained under this subdivision indicates that the person has been denied a license, certification, certificate of approval or registration, continuation of a license, certification, certificate of approval or registration, a contract, employment or permission to reside as described in this subdivision, the entity need not obtain the information specified in subds. 1. to 4. This Rule is not met as evidenced by: Based on interview and record review, the provider did not complete a caregiver background check for Caregiver C. The provider did not have an arrest history from the Department of Justice (DOJ) or an Integrated Background Information System (IBIS) review letter from the department for Caregiver C. Findings include: According to The Wisconsin Caregiver Program Manual (P-00038), Wis. Stat. ch. 50, and Wis. Admin. Code ch. 12, a complete CBC, at	Z 005		

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minimum, consists of:
"1) A completed DHS form F-82064, Background Information Disclosure (BID).
2) A response from the Department of Justice (DOJ).
3) A 'Response to Caregiver Background Check' letter from the Department of Health Service, also referred to as the Integrated Background Information System (IBIS)."

On 03/20/2024 at 1:50 PM, Surveyor requested the complete caregiver background check for Caregiver C. At approximately 3:30 PM, Surveyor interviewed Regional Nurse (RN) A. RN A stated s/he could not locate the background check for Caregiver C but would continue to look for it.

On 03/28/2024 at 1:45 PM, Surveyor requested via email Caregiver C's DOJ and IBIS.

On 04/01/2024 at 2:25 PM, Surveyor received an email from RN A that included a DOJ and IBIS for Caregiver C. Surveyor reviewed the DOJ and IBIS, which were dated 03/22/2024. The DOJ and IBIS were completed after Caregiver C's hire date of 01/18/2024.

On 04/16/2024 at 3:30 PM, Surveyor interviewed RN A, Director B, and Regional Operations Director (ROD) I. RN A stated s/he did not notice the date on the DOJ and IBIS provided on 04/01/2024 via email was incorrect. RN A stated Assistant Director (AD) G (who no longer worked at the facility) was asked to find the document and did not do it correctly. RN A stated AD G must have had Caregiver C fill out the form again. RN A stated s/he would find and send the original DOJ and IBIS.

On 04/17/2024 at 8:39 AM, Surveyor received an

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VITACARE LIVING BLOOMER I	406 PRIDDY ST BLOOMER, WI 54724

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Z 005	Continued From page 41 email from RN A that read, in part, "We unfortunately cannot locate the BID/background..." The provider did not complete a caregiver background check when Caregiver C did not have a DOJ or IBIS in his/her record at hire.	Z 005		
Z 024	50.065(4m)(c) COMPLETE BACKGROUND INFORMATION DISCLOSURE If the background information form completed by a person under sub. (6) (am) indicates that the person is not ineligible to be employed or contracted with for a reason specified under par. (b) 1. to 5., an entity may employ or contract with the person for not more than 60 days pending the receipt of the information sought under sub. (2) (b). If the background information form completed by a person under sub. (6) (am) indicates that the person is not ineligible to be permitted to reside at an entity for a reason specified in par. (b) 1. to 5. and if an entity otherwise has no reason to believe that the person is ineligible to be permitted to reside at an entity for any of these reasons, the entity may permit the person to reside at the entity for not more than 60 days pending receipt of information sought under sub. (2) (am). An entity shall provide supervision for a person who is employed or contracted with or permitted to reside as permitted under this paragraph. This Rule is not met as evidenced by:	Z 024		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019745	A. BUILDING: _____ B. WING _____	C 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING BLOOMER I	406 PRIDDY ST BLOOMER, WI 54724

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Z 024	Continued From page 42 Based on record review and interview, the provider did not ensure a background information disclosure (BID) form was completed for 1 of 5 records reviewed. Findings include: On 03/20/2024 at 1:50 PM, Surveyor requested a sample of employee records for review. Caregiver C had a hire date of 01/18/2024 and did not have a BID form completed in his/her record. On 03/28/2024 at 1:45 PM, Surveyor requested Caregiver C's BID via email. On 04/01/2024 at 2:25 PM, Surveyor received an email from Registered Nurse (RN) A that included a BID for Caregiver C. Surveyor reviewed the BID, which was dated 03/21/2024. The BID was completed after Caregiver C's hire date of 01/18/2024. On 04/16/2024 at 3:30 PM, Surveyor interviewed RN A, Director B, and Regional Operations Director (ROD) I. RN A stated s/he did not notice the date on the BID provided on 04/01/2024 via email was incorrect. RN A stated Assistant Director (AD) G (who no longer worked at the facility) was asked to find the document and did not do it correctly. RN A stated AD G must have had Caregiver C fill out the form again. RN A stated s/he would find and send the original BID. On 04/17/2024 at 8:39 AM, Surveyor received an email from RN A that read, in part, "We unfortunately cannot locate the BID/background..."	Z 024		