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N 000	Initial Comments On 11/07/2023, with information gathered through 11/16/2023, Surveyor conducted a standard licensure survey at Autumn Winds LLC. Twelve deficiencies were identified. Census: 8	N 000		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not develop a comprehensive Individual Service Plan (ISP) for 1 of 1 resident reviewed. Resident 2's ISP did not document that s/he utilized oxygen. Findings include: On 11/07/2023, at approximately 1:10 PM,	N 386		

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

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N 386	Continued From page 1 Surveyor toured Resident 2's room and observed oxygen tanks and an oxygen concentrator in his/her room. On 11/07/2023, at approximately 1:35 PM, Surveyor toured the facility dining room and observed Resident 2's designated sitting area which had oxygen tubing resting on the table. On 11/07/2023, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility, 02/02/2023, with diagnoses including chronic respiratory failure, dizziness, anxiety, hallucinations, and arthritis. Resident 2's ISP, dated 02/02/2023, documented: "General Health: Overall good health" "Chronic Illnesses: Respiratory failure with hypoxia (low levels of oxygen in your body tissues)" Surveyor noted there was no documented guidelines regarding oxygen usage. On 11/16/2023, at approximately 3:50 PM, Surveyor interviewed Administrator A. Administrator A stated that when Resident 2 was admitted to the facility s/he utilized his/her oxygen primarily during sleeping hours. Administrator A stated that Resident 2 was increasing his/her usage of oxygen. Administrator A stated Resident 2's ISP should have documented that s/he utilized oxygen and would update the ISP accordingly.	N 386		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when	N 389		

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there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the Individual Service Plan (ISP) was updated when there was a change in needs and physical or mental condition for 1 out of 1 resident.

Resident 5's ISP was not updated to include PRN (as needed) behavioral medication and did not document that s/he was on tube feeding.

Findings include:

The provider is licensed to provide services for up to 10 residents in the client groups: advanced aged, irreversible dementia/Alzheimer's, physically disabled, developmentally disabled, traumatic brain injury and terminally ill.

On 11/07/2023, Surveyor reviewed Resident 5's record.

Resident 5 was admitted, 11/28/2022, with diagnoses including autism, bipolar, seizures, intellectual and developmental disabilities,

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self-abusive behavior, and aggressive behavior.

Resident 5's "Agitation/Aggressive Protocol," dated 11/22/2022, documented:
"[Resident 5] has a history of SIB (self-injurious behavior) with head banging, biting [her/himself] in the hand and arm, pinching [his/her] arms and legs, and kicking and hitting others. ... [Resident 5] has a history of becoming agitated towards other clients and staff. [Resident 5] has a history of physical and property destruction. ... What to do: If SIB continues PRN will be given."

Resident 5's November 2023 Medication Administration Record did not document any PRN medications for behaviors.

Resident 5's "Resident Care Card," undated, documented:
"Feeding: Pureed/Pump at Night"
"3 Jevity cans in pump bag set at 100 head 45° angle"
Resident 5's care card did not document that s/he was prescribed a PRN psychotropic medication.

Resident 5's ISP, dated 11/28/2022, documented:
"Eating: Resident is able to feed [him/herself] when [s/he] feels like it."
"Dietary: Resident is pureed meals with nectar thickened liquids. Occasionally will cough when eating or drinking."
Resident 5's ISP did not document that s/he was prescribed a PRN psychotropic medication.

On 11/16/2023, at approximately 3:50 PM, Surveyor interviewed Administrator A. Surveyor asked if Resident 5's "Agitation/Aggressive Protocol" was to be considered part of his/her ISP as the protocol documented that Resident 5 was to receive a PRN medication for behaviors, but

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N 389	Continued From page 4 his/her ISP did not document an actual PRN medication. Administrator A stated the protocol was considered a part of Resident 5's ISP. Administrator A stated s/he was newer to the administrator role and was not aware of any PRN behavioral medication that Resident 5 would have been on. Surveyor stated Resident 5's "Resident Care Card" documented that s/he received pump feeding in the evening, but his/her ISP did not document that. Administrator A stated Resident 5 received his/her evening meal via the pump while s/he slept and, in the morning, received water through the pump to ensure hydration. Administrator A stated s/he would review Resident 5's ISP to ensure accuracy.	N 389		
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 ensure 2 of 2 resident (Resident 1 and Resident 6) reviewed was evaluated annually to determine their mental or physical capability to respond to a fire alarm. Findings include: The provider is licensed to provide services for up to 10 residents in the client groups: advanced aged, irreversible dementia/Alzheimer's, physically disabled, developmentally disabled, traumatic brain injury and terminally ill.	N 394		

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N 394	Continued From page 5 On 11/07/2023, Surveyor reviewed Resident 1's and Resident 6's record. Resident 1's current evacuation assessment was dated 07/2019. Resident 1 did not have an annual evaluation of evacuation limits in 2020, 2021, 2022 and 2023. Resident 6's current evacuation assessment was dated 06/18/2021. Resident 6 did not have an annual evaluation of evacuation limits in 2022 and 2023. On 11/16/2023, at approximately 3:50 PM, Surveyor interviewed Administrator A. Administrator A stated s/he did not know the assessments had to be reviewed annually and would review all resident files.	N 394		
N 412	83.37(2)(a) Self-administered by resident. Self-administered by resident. 1. The resident shall self-administer prescribed and over-the-counter medications and dietary supplements, unless the resident has been found incompetent under ch. 54, Stats., or does not have the physical or mental capacity to self-administer as determined by the resident ' s physician, or the resident requests in writing that CBRF employees manage and administer medication. 2. Except as specified under sub. (4), when a resident self-administers medications, prescribed and over-the-counter medications and dietary supplements shall remain under the control of the resident. The CBRF shall provide a secure place for the storage of medications in the resident ' s room. 3. A resident with the mental and physical capacity to develop increased independence in	N 412		

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medication administration shall receive self-administration instruction.

This Rule is not met as evidenced by:
Based on observed, record review and interview, the provider did not have an order in writing for 1 of 1 resident (Resident 2) from his/her physician that s/he had the physical or mental capacity to self-administer his/her medications.

Findings include:

On 11/07/2023, at approximately 1:00 PM, Surveyor toured Resident 2's bedroom and observed 42 caplet bottle of Imodium (anti-diarrhea medication), diclofenac sodium topical gel, and (3) 30-gram bottles of nystatin topical powder sitting on an open shelf. Surveyor noted the nystatin powders were expired.

On 11/07/2023, Surveyor reviewed Resident 2's record.

Resident 2 was admitted to the facility, 02/02/2023, with diagnoses including chronic respiratory failure, dizziness, anxiety, hallucinations, and arthritis.

Resident 2's individual service plan, dated 03/20/2023, documented:
"Medications: Medications administered by CBRF (community-based residential facility) staff."
"Capacity for Self-Direction: Needs assistance."

Resident 2's October 2023 Medication Administration Record documented:
"Diclofenac gel: Apply two grams topically to knees four times daily for pain. Allow at bedside for patient to self-administer." Surveyor noted the

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N 412	Continued From page 7 Imodium, and the nystatin powder was not listed on the medication administration record. On 11/16/2023, at approximately 3:50 PM, Surveyor interviewed Administrator A. Administrator A stated s/he would review the medications in Resident 2's room and obtain the necessary physician order for self-administration.	N 412		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure proper documentation within the Medication Administration Record (MAR) for 4 of 6 residents reviewed. Resident 1's Resident 2, Resident 3, Resident 5, and Resident 7 had blanks on the MAR where scheduled medication administration should have been documented and/or medications documented as	N 415		

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administered that had not been.

Findings include:

On 11/07/2023, at approximately 12:30 PM, Surveyor reviewed the provider's November 2023 MAR binder which contained the resident's monthly MARs which documented the area for caregivers to initial medication administration was left blank for the following medication administration dates with no documented rationale or was documented as administered when the medication had not been dispensed:

Example 1: Resident 2
Diclofenac Gel - Apply two grams topically to knees four times daily for pain. Allow at bedside for patient to self-administer. Scheduled at 8:00 AM, Noon, 4:00 PM and 8:00 PM.
11/07/2023 at 8:00 PM was documented as administered.
Florajen 3, Ketotifen Ophthalmic, Metoprolol, morphine sulfate, Oxybutynin, Oxycodone and Pantoprazole - Scheduled at 8:00 PM.
11/07/2023 was documented as administered.

Example 2: Resident 3
Check blood sugar twice daily - PM.
11/07/2023 was documented as completed.
Levetiracetam - Take one tablet by mouth twice daily. Scheduled at 9:00 PM.
11/07/2023 was documented as administered.

Example 3: Resident 5
Zonisamide - Take 1 capsule every morning. Scheduled at 8:00 AM.
No documented administration from 11/01/2023 to 11/07/2023.
Lithium Carb - Take 1 capsule by mouth every evening. Scheduled at 5:00 PM.

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N 415	Continued From page 9 No documented administration from 11/01/2023 to 11/04/2023 and 11/06/2023. Melatonin - Take 1 tablet by mouth at bedtime. Scheduled at 8:00 PM. No documented administration from 11/01/2023 to 11/04/2023. Surveyor noted 11/07/2023 was documented as administered. Lamotrigine - 100 MG (milligram) - Take 1 tablet by mouth at bedtime for 1 week then take 1 tablet by mouth 2 times daily for 1 week then take 1 and ½ tablets 2 times daily thereafter. No documented administration from 11/01/2023 to 11/07/2023. Saline - Nasal Spray - 2 sprays nasal BID (twice a day). No documented administration from 11/01/2023 to 11/07/2023. Santyl ointment - application topical Monday, Wednesday, Friday. Administration was documented for the month. Example 4: Resident 7 Doxazosin Mesylate and Melatonin. Scheduled at 8:00 PM. 11/07/2023 was documented as administered. On 11/16/2023, at approximately 3:50 PM, Surveyor interviewed Administrator A. Administrator A stated s/he would discuss the importance of proper medication administration documentation with staff. Administrator A stated s/he would discuss having medication start and end dates documented on the MARs. Cross Reference: N0432 DHS 83.38(1)(h) Medication Administration	N 415		
N 417	83.37(3)(a) Medication storage: original containers.	N 417		

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N 417	Continued From page 10 Original containers. The CBRF shall keep medications in the original containers and not transfer medications to another container, unless the CBRF complies with all of the following: 1. Transfer of medications from the original container to another container shall be done by a practitioner, registered nurse, or pharmacist. Transfer of medication to another container may be delegated to other personnel by a practitioner, registered nurse or pharmacist. 2. If a medication is administered by CBRF employees and the medication is transferred from the original container by a registered nurse, or practitioner or other personnel who were delegated the task, the CBRF shall have a legible label on the new container that includes, at a minimum, the resident ' s name, medication name, dose and instructions for use. The CBRF shall maintain the original pharmacy container until the transferred medication is gone. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 3 out of 3 resident medications that were transferred from their original containers were done so by an appropriate party, were labeled with resident name, medication name and dose, and instructions for use. Resident 4's , Resident 5's, and Resident 6's medications were not transferred from their original container by an appropriate party or by an individual appropriately delegated to do so. Resident 4's , Resident 5's, and Resident 6's medications were not labeled after being transferred from their original containers.	N 417		

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Resident 4's , Resident 5's, and Resident 6's medications were dispensed prior to the scheduled medication administration time.

Findings include:

The provider is licensed to care for 35 residents in the following client groups: advanced aged, irreversible dementia/Alzheimer's disease, physically disabled and terminally ill.

On 11/07/2023, at approximately 1:20 PM, Surveyor observed the medication closet and located glass med cups with the resident names written on them and medications were dispensed into the cups. Surveyor reviewed resident Medication Administration Records (MAR) and resident medication blister cards to determine what medications had been dispensed:

Resident 1's October 2023 MAR documented potassium and warfarin were to be administered at 5:00 PM. Surveyor reviewed the medication blister cards and determined the meds had been dispensed.

Resident 4's October 2023 MAR documented Lisinopril, Metoprolol, and Baclofen were to be administered at 5:00 PM. Surveyor reviewed the medication blister cards and determined the meds had been dispensed.

Resident 5's October 2023 MAR documented calcium, Risperidone, vitamin B-6 and Metoclopramide were to be administered at 5:00 PM. Surveyor reviewed the medication blister cards and determined the meds had been dispensed.

Resident 6's October 2023 MAR documented

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N 417	Continued From page 12 acetaminophen and senna were to be administered at 5:00 PM and Omeprazole were to be administered at 8:00 PM. Surveyor reviewed the medication blister cards and determined the meds had been dispensed. On 11/07/2023, at approximately 1:30 PM, Surveyor interviewed Med Passer B. Surveyor stated that s/he observed medications that had been signed out as dispensed on the MARs and the medications were sitting in cups in the medication closet. Med Passer B stated s/he had prepped the 5:00 PM medications for administration. On 11/16/2023, at approximately 3:50 PM, Surveyor interviewed Administrator A. Administrator A stated Med Passer B should not have pre-dispensed the medications. Administrator A stated s/he would speak with staff about proper medication administration.	N 417		
N 420	83.37(3)(d) Medication storage: refrigeration Refrigeration. Medications stored in a common refrigerator shall be properly labeled and stored in a locked box. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure medications stored in the common refrigerator were stored in a locked box. Resident 2's blister cards of Florajen (probiotic) were stored unsecured in the common refrigerator. Resident 3's pens of Lantus Solostar (insulin) were stored unsecured in the common refrigerator.	N 420		

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N 420	Continued From page 13 Findings include: On 11/07/2023, at approximately 11:25 AM, Surveyor observed the refrigerator in the kitchen. Stored on the shelf in the door of the refrigerator, along with a jar of jelly, were 2 blister cards of Resident 2's Florajen and 4 pens of Resident 3's Lantus Solostar. On 11/16/2023, at approximately 3:50 PM, Surveyor interviewed Administrator A. Administrator A stated the blister packs did not fit into the lock box as the lock box was full of a resident's eye drops. Administrator A stated staff should not be storing food in the designated medication area of the refrigerator.	N 420		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that the clothes dryer in the residential laundry room had vent tubing of rigid material, with a fire rating that exceeds the temperature rating of the dryer. The clothes dryer was observed to have the flexible foil type vent tubing. Findings include:	N 488		

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	0016509	A. BUILDING: _____ B. WING _____	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN WINDS LLC	N3767 AIRPORT RD CAMBRIDGE, WI 53523

(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 488	Continued From page 14 On 11/07/2023, at approximately 11:15 AM, during a tour of the facility, Surveyor observed a foil accordion style vent tubing from residential clothes dryer to vent duct. On 11/16/2023, at approximately 3:50 PM, Surveyor interviewed Administrator A. Administrator A stated s/he would have the dryer venting replaced.	N 488		
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 cleaning compounds and toxic substances were stored in a secured area. Surveyor observed cleaning compounds unsecure in the bathroom, laundry room and kitchen area. Findings include: The facility is licensed as a Class CNA (non-ambulatory) CBRF (community based residential facility) able to serve up to 10 residents within the client groups of advanced age, terminally ill, physically disabled, developmentally disabled, traumatic brain injury, and irreversible dementia/Alzheimer's. On 11/07/2023, at approximately 11:00 AM, Surveyor conducted a tour of the facility and	N 499		

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N 499	Continued From page 15 observed the following unsecured cleaning compounds: -Sitting on the kitchen counter: 32 fluid ounce spray bottle of heavy-duty non-acid washroom cleaner -Laundry Room A clear bowl of what appeared to be a powder laundry detergent 32 fluid ounce spray bottle of sanitizer (4) 24 fluid ounce bottles of toilet bowl cleaner -Bathroom 32 fluid ounce spray bottle of heavy-duty non-acid washroom cleaner 32 fluid ounce spray bottle of sanitizer -Resident 2's bedroom 19 ounce spray can of disinfectant spray sitting in his/her recliner On 11/16/2023, at approximately 3:50 PM, Surveyor interviewed Administrator A. Administrator A stated toxic chemicals should be secured and would discuss the concern with staff.	N 499		
N 530	83.47(3) Fire inspection. Fire inspection. The CBRF shall arrange for an annual inspection by the local fire authority or certified fire inspector and shall retain fire inspection reports for 2 years. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have an annual fire inspection conducted by the local fire marshal or certified inspector for the calendar year 2022. Findings include:	N 530		

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N 530	Continued From page 16 On 11/07/2023, Surveyor requested the annual fire inspection documentation for 2022. Administrator A provided Surveyor with a binder that contained all life safety documentation. Surveyor was unable to locate the 2022 fire inspection. On 11/08/2023 at 11:22 AM, Surveyor emailed Administrator A stating that the 2022 fire inspection was not located in the life safety binder. On 11/08/2023, Surveyor reviewed the Department's facility file and no waivers for fire inspections were filed. On 11/16/2023, at approximately 3:50 PM, Surveyor interviewed Administrator A. Administrator A stated s/he was unable to locate the documentation and would make contact with the fire department regarding the 2023 inspection.	N 530		
N 531	83.47(4)(a) Fire extinguishers: type and inspection. At least one portable dry chemical fire extinguisher with a minimum 2A, 10-B-C rating shall be provided on each floor of the CBRF. All fire extinguishers shall be maintained in readily usable condition. Inspections of the fire extinguisher shall be done by a qualified professional one year after initial purchase and annually thereafter. Each fire extinguisher shall be provided with a tag documenting the date of inspection. This Rule is not met as evidenced by:	N 531		

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N 531	Continued From page 17 Based on observation and interview, the provider did not ensure fire extinguisher inspections were done by a qualified professional one year after initial purchase and annually thereafter. Two fire extinguishers observed had not been annually inspected in 2023. Findings include: On 11/07/2023, at approximately 1:00 PM, Surveyor toured the facility. Surveyor observed 2 ABC type fire extinguisher located throughout the facility. The service date on the fire extinguishers were 03/2022. On 11/16/2023, at approximately 4:00 PM, Surveyor interviewed Administrator A. Surveyor and Administrator A reviewed the life safety documentation which confirmed that the fire extinguishers had not been serviced in 2022. Administrator A stated s/he would contact the vendor who is responsible for these inspections. On 11/16/2023, at approximately 3:50 PM, Surveyor interviewed Administrator A. Administrator A stated s/he would arrange for the fire extinguishers to be inspected.	N 531		
N 640	83.59(2)(b) Solid core wood doors or equivalent A solid core wood door or an equivalent fire resistive door shall be provided at any interior stair between the basement and the first floor. The door shall have a positive latch and an automatic closing device and normally shall be kept closed. Enclosed furnace and laundry areas with self-closing doors in a split level home may substitute for the self-closing door between the first and second levels. Enclosed furnace and	N 640		

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N 640	Continued From page 18 laundry areas shall have self-closing solid core wood doors or an equivalent fire resistive door when located on a common level with resident bedrooms. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the door leading to the basement was self-closing, which is located on the same floor as resident bedrooms. Findings include: On 11/07/2023, at approximately 1:50 PM, Surveyor toured the facility. Surveyor observed the door leading to the basement was not self-closing. Med Passer B informed Surveyor that residents do not go downstairs. On 11/16/2023, at approximately 3:50 PM, Surveyor interviewed Administrator A. Administrator A stated s/he was not aware that the basement door needed to be self-closing and would address that concern.	N 640		