STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 01/24/2024, Surveyors conducted one (1) complaint investigation at Marvins Manor IV. As a result of the survey the complaint was substantiated. Fifteen deficiencies were identified. Four of the 15 were repeat deficiencies. Census: 17	N 000		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. On 01/18/2024 with information gathered through 01/24/2024, Surveyors investigated one (1) complaint. Fifteen deficiencies were identified. Four of the 15 deficiencies were repeat violations. See Statement of Deficiency (SOD) S7O211, dated 01/25/2023; SOD 6DZK11, dated 06/07/2022; SOD OX9711, dated 04/23/2019. Findings Include: The facility is a 25-bed CBRF that serves individuals who may be terminally ill, advanced age, and/or have irreversible dementia/Alzheimer's. During the previous survey, concluded on	N 196		

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
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 196	Continued From page 1 12/27/2023, Licensee C was invited to an exit conference with Surveyors. At that time, Licensee C told Surveyors s/he was selling the business to Managing Partner (MP) G. Licensee C acknowledged s/he did not have knowledge of the concerns in the facility as s/he thought the change of ownership had happened, even though s/he was confused why his/her license was still on the wall. Surveyor confirmed department records and informed Licensee C that the change of ownership had not occurred and that s/he was still the licensee and responsible for the facility. Surveyors shared the change of ownership could not be processed until the facility reached substantial compliance and that the pending change of ownership had been closed due to inactivity. Surveyors informed Licensee C a deficiency would be issued based on his/her investigation, indicating the facility was not in substantial compliance. Deficiencies identified on Statement of Deficiency (SOD) 0QN911, dated 12/27/2023: N0348 DHS 83.32(3)(d) Rights Of Resident: Free From Mistreatment Based on record review and interview, the provider did not ensure 1 of 1 resident was free from misappropriation of property. Resident 3 had money taken from a locked box in a locked office. N0368 DHS 83.34(2)(b) Accounting Method For Tracking Petty Cash Based on record review and interview, the provider did not ensure 1 of 1 resident was free from misappropriation of property. Resident 3 had money taken from a locked box in a locked office N0481 DHS 83.43(1) Environment Safe, Clean	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 196	Continued From page 2 and Comfortable Based on observation and interview, the provider did not ensure a living environment that was safe, clean, comfortable and homelike for residents. N0502 DHS 83.46(1)(a) Comfortable and Safe Temperature Based on observations, resident and staff interviews, the provider did not maintain a temperature of 74 degrees Fahrenheit in areas occupied by residents. N0503 DHS 83.46(1)(b) Portable Space Heater Based on observation and staff and resident interviews the provider did not ensure free standing portable space heaters were not in use in the facility. During survey on 12/13/2023 Surveyors observed portable space heaters in use in Resident 2's room. On 01/18/2024, Surveyors conducted a complaint investigation alleging staffing concerns, cleaning of the facility, supplies (gloves, toilet paper, cleaning), hours staff are working, staff not meeting resident needs, resident cares not being completed, lack of food, staff not trained, staff backgrounds not checked and not qualified to provide cares. Additional information was gathered through 01/24/2024. On 01/18/2024, Surveyors entered the facility and observed resident cares not completed. Resident rooms with odor of urine and food not stored properly. Surveyors observed staff working and interviewed staff regarding training. Staff confirmed they were medication passers but did not receive nurse delegation to check blood sugars, administer insulin and do suppositories. On 01/24/2024 at 9:30 AM, Surveyors exited with	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 196	Continued From page 3	N 196		

Licensee C and Licensee L regarding the findings of the survey conducted on 01/18/2024. Licensee C stated s/he is taking the building back and MP G will no longer be purchasing his/her facility. Licensee C acknowledged "It's a mess, but we'll get there." "We want to go back in and make it a great place." As a result of Licensee C not holding his/her responsibilities as the licensee, the complaint was substantiated resulting in 16 deficiencies from the 01/18/2024 survey. Four of the 16 deficiencies were repeat violations:

N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies with Laws
Based on record review and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF.

N0219 DHS 83.17(1) Licensee Conduct Caregiver Background Check
Based on record review and interview, the provider did not ensure 4 out of 4 employees (Caregiver D, Caregiver E, Caregiver F and Managing Partner (MP) G) reviewed had a complete caregiver background check done upon hire.

This is a repeat deficiency. See Statement of Deficiency (SOD) S7O211, dated 01/25/2023.

N0220 DHS 83.17(1)(a) Employees Screened For Communicable Disease
Based on record review and interview, the provider did not obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating 4 of 4 employees reviewed were screened for clinically apparent communicable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 196	Continued From page 4 disease within 90 days before the start of employment, including tuberculosis. N0230 DHS 83.19 Orientation Based on record review and interview, the provider did not ensure 3 of 3 employees (Caregiver E, Caregiver F and Managing Partner (MP) G) reviewed obtained all orientation training as required prior to performing any job duties. N0239 DHS 83.20(2)(a)-(d) Department Approved Training Courses Based on interview and record review, the provider did not ensure 1 of 1 employee obtained all department approved training as required. N0243 DHS 83.21(1)-(3) All Employee Training Based on record review and interview, the provider did not ensure 1 of 1 employee reviewed, obtained all training as required within 90 days after starting employment. N0277 DHS 83.25 Continuing Education Based on record review and interview, the provider did not ensure all resident care staff received continuing education which includes client group, resident rights, medications and fire safety and emergency procedures, for 1 of 1 staff (Managing Partner (MP) G). This is a repeat deficiency. See Statement of Deficiency (SOD) OX9711, dated 04/23/2019. N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication Based on record review and interview, the provider did not ensure 2 of 2 resident reviewed received prescribed medications in the dosage and intervals as prescribed.	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 196	Continued From page 5 This is a repeat deficiency. See Statement of Deficiency (SOD) S7O211, dated 01/25/2023. N0353 DHS 83.32(3)(i) Rights of Residents: Adequate Treatment Based on record review and interview, the provider did not ensure prompt and adequate treatment appropriate to the resident's needs was obtained for 6 of 6 Residents (Resident 1, Resident 5, Resident 7, Resident 8, Resident 9 and Resident 10). N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan Based on record review, observation and interview, the provider did not ensure Individual Support Plans (ISP) were being implemented and followed as written for Resident 4. N0389 DHS 83.35(3)(d) Service Plans Updated Annually or On Changes Based on record review and interview, the provider did not review and revise the individual service plan (ISP) annually or on change of condition for one (1) of 1 resident reviewed. This is a repeat deficiency. See Statement of Deficiency (SOD) 6DZK11, dated 06/07/2022. N0416 DHS 83.37(2)(e) Other Administration Given Or Delegated By RN Based on record review and interview, the provider did not ensure injectable's, stomal and enteral medications, treatments or preparations delivered vaginally or rectally were administered by a registered nurse (RN), licensed practical nurse (LPN), or delegated to unlicensed caregivers for Resident 2, Resident 3, Resident 5 and Resident 6, pursuant to the Nurse Practice Act [s. N 6.03(3)] and in accordance with	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 196	Continued From page 6 accepted standards of practice for 2 of 2 unlicensed caregivers (Caregiver D and Caregiver E) reviewed. N419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet Based on observation and staff interview, the provider did not ensure 17 of 17 residents' medications were securely stored. N0452 DHS 83.41 (3)(b) Food Safety Based on observation and interview, the provider did not ensure food was stored under sanitary conditions to prevent food borne illness. The provider did not properly seal and label open food. N0637 DHS 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways Based on observation and interview, the provider did not ensure that the outside driveway, sidewalk off the 2 side exits of the facility, back exit and walkways leading to the entrance of the facility were clear of ice/snow. These actions affected 17 residents.	N 196		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of	N 219		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 219	Continued From page 7 misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 out of 4 employees (Caregiver D, Caregiver E, Caregiver F and Managing Partner [MP] G) reviewed had a complete caregiver background check done upon hire. This is a repeat deficiency. See Statement of Deficiency (SOD) S7O211, dated 01/25/2023. Findings include: The facility is licensed to provide services for up to 25 residents who may be terminally ill, advanced aged and/or irreversible dementia/Alzheimer's. The census at time of survey was 17. According to The Wisconsin Caregiver Program Manual (P-00038), Wis. Stat. ch. 50, and Wis. Admin. Code ch. 12, a complete CBC, at 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).	N 219		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 219	Continued From page 8 On 01/18/2024, Surveyors requested employee files and caregiver background checks for Caregiver D, Caregiver E, Caregiver F and MP G. Manager B provided Surveyors with employee files. Caregiver D had a hire date of 01/15/2024. Caregiver D's record was reviewed, and Surveyor observed a completed BID, however no documentation that the provider completed the DOJ and IBIS background. Caregiver E had a hire date of 01/10/2024. Caregiver E's record was reviewed, and Surveyor observed no information had been completed including BID, DOJ and IBIS upon his/her new hire. Caregiver F had a hire date of 01/15/2024. Caregiver F's record was reviewed, and Surveyor observed no information had been completed including BID, DOJ and IBIS upon his/her new hire. MP G was working with Licensee C to take over the facility and s/he assumed responsibilities as of July 2023 according to information Administrator A provided. There was no record provided for MP G. On 01/18/2024, Surveyor interviewed Administrator A and Manager B. Administrator A stated s/he did not have Caregiver D's DOJ and IBIS, and that s/he had not had Caregiver E and Caregiver F complete a BID upon their hire as they were employed at this facility in the past. Administrator A stated s/he would send Surveyor MP G's record when s/he receives from a sister facility.	N 219		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 219	Continued From page 9 On 01/22/2024 at 3:58 PM, Surveyor emailed Administrator A confirming s/he had no record for MP G. At 4:33 PM, Administrator A replied, "Yes, that is correct." House Manager B was unable to provide Surveyors with the DOJ and DHS information for 3 of 3 employees reviewed. On 01/24/2024 at 9:30 AM, Surveyor exited with Licensee C. Licensee C acknowledged s/he was not keeping all the staff hired by MP G. Licensee C stated "it is going to be new staff. I'm going to redo background checks and all new documentation and paperwork for all staff hired/retained." The provider did not ensure 4 out of 4 employees reviewed had a complete caregiver background check done upon hire.	N 219		
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.	N 220		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 220	Continued From page 10 This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating 4 of 4 employees reviewed were screened for clinically apparent communicable disease within 90 days before the start of employment, including tuberculosis. Findings include: On 01/18/2024, Surveyor requested Caregiver D, Caregiver E, Caregiver F and Managing Partner (MP) G's employee records from Administrator A and Manager B. Administrator A provided Surveyors with Caregiver D, Caregiver E and Caregiver F's employee record, but stated s/he needed time to have MP G's employee record sent to the facility. Administrator A acknowledged MP G does work with residents and fills in when there is a staff shortage. Caregiver D had a hire date of 01/15/2024. Caregiver D's record did not have documentation that Caregiver D had been screened for clinically apparent communicable disease within 90 days before the start of employment, including tuberculosis. Surveyor observed an annual screen completed on 01/12/2024 by Caregiver D. Caregiver E had a hire date of 01/10/2024. Caregiver E's record did not have documentation that Caregiver E had been screened for clinically apparent communicable disease within 90 days before the start of employment, including tuberculosis. Caregiver F had a hire date of 01/15/2024.	N 220		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 220	Continued From page 11	N 220		

Caregiver F's record did not have documentation that Caregiver F had been screened for clinically apparent communicable disease within 90 days before the start of employment, including tuberculosis.

On 01/15/2024 at 1:32 PM, Surveyor interviewed Administrator A about the screening for clinically apparent communicable disease within 90 days of employment, including tuberculosis. Administrator A stated s/he believed Caregiver D was scheduled for tuberculosis and communicable disease next week. Administrator A acknowledged Caregiver E and Caregiver F were not screened for communicable disease including tuberculosis prior to their date of hire. Manager B acknowledged s/he had not had Caregiver D, Caregiver E and Caregiver F screened for communicable disease, including tuberculosis. Administrator A stated "OK".

On 01/15/2024, Surveyor reviewed department records and verified the provider did not have any approved waivers related to Employee Communicable Disease Screening.

On 01/22/2024, Surveyor received an email from Administrator A referencing training, no documentation that MP G had been screening for communicable disease, including tuberculosis. MP G's date of hire is prior to 2016. Interview with staff and residents confirmed MP G has worked with residents and filled in when there is a staff shortage.

On 01/24/2024 at 9:30 AM, Surveyor exited with Licensee C. Licensee C acknowledged new staff were not screened for communicable disease screening including tuberculosis within 90 days of hire and stated s/he would ensure all staff are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 220	Continued From page 12 screened for communicable disease including tuberculosis.	N 220		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 employees (Caregiver E, Caregiver F and Managing Partner [MP] G) reviewed obtained all orientation training as required prior to performing any job duties. Findings include: The facility is licensed to provide services for up to 25 residents who may be terminally ill, advanced aged and/or irreversible dementia/Alzheimer's. On 01/18/2024, Surveyor requested Caregiver E, Caregiver F and MP G's employee records from Administrator A and Manager B. Administrator A stated s/he needed time to gather the information	N 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 230	Continued From page 13 for MP G, as it would be sent from a sister facility. Manager B provided Surveyors with Caregiver E and Caregiver F's employee record. Caregiver E had a hire date of 01/10/2024. Caregiver E's employee file had no evidence Caregiver E had all required orientation upon hire and before performing any job duties. There was no evidence Caregiver E was orientated in job responsibilities; prevention and reporting of resident abuse, neglect and misappropriation; community based residential facility (CBRF) policies and procedures; information regarding assess needs and individual services; emergency and disaster and evacuation procedures; and change in condition. Caregiver F had a hire date of 01/15/2024. Caregiver F's employee file had no evidence Caregiver F had all required orientation upon hire and before performing any job duties. There was no evidence Caregiver F was orientated in job responsibilities; prevention and reporting of resident abuse, neglect and misappropriation; CBRF policies and procedures; information regarding assess needs and individual services; emergency and disaster and evacuation procedures; and change in condition. MP G had a hire date prior to 2016. MP G's employee file had no evidence MP G had all required orientation upon hire and before performing any job duties. There was no evidence MP G was orientated in job responsibilities; prevention and reporting of resident abuse, neglect and misappropriation; community based residential facility (CBRF) policies and procedures; information regarding assess needs and individual services; emergency and disaster and evacuation procedures; and	N 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 230	Continued From page 14 change in condition. On 01/15/2024 at 1:32 PM, Surveyor interviewed Administrator A and Manager B regarding employee orientation. Administrator A confirmed they hired eight (8) new employees in January 2024. Administrator A stated Caregiver E and Caregiver F had been employed at the facility prior, however they both terminated employment. Administrator A confirmed s/he had hired Caregiver E with a start date of 01/10/2024 and Caregiver F with a start date of 01/15/2024. Manager B had provided Surveyor with the old employee records from prior employment. Manager B acknowledged s/he had not completed new employee orientation with Caregiver E and Caregiver F. On 01/22/2024 at 11:22 AM, Surveyor received an email from Administrator A referencing training for MP G, which stated, "After searching all files, I did not find [his/her] certs [sic] from 2016." Administrator A confirmed MP G has worked and helps when needed. Interview with staff and residents confirmed MP G has worked with residents and filled in when there is a staff shortage. On 01/24/2024 at 9:30 AM, Surveyor exited with Licensee C. Licensee C acknowledged s/he needed to work on the orientation documentation to ensure new staff receive training required and that trainers complete the documentation and return the documentation to him/her. Cross reference DHS 83.20(2)(a)-(d) Department Approved Training Courses DHS 83.21(1)-(3) All Employee Training DHS 83.25 Continuing Education	N 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 1 of 1 employee obtained all department approved training as required. Managing Partner (MP) G did not have training in fire safety and first aid and choking with 90 days after starting employment and standard precautions prior to working with residents.	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 239	Continued From page 16 Findings include: On 01/18/2024, Surveyor requested MP G's employee record from Administrator A and Manger B. Administrator A stated s/he needed to have a sister facility send over MP G's employee file. Administrator A confirmed s/he was having trouble receiving MP G's employee file and s/he would send the information to Surveyor. Administrator A acknowledged MP G does work with residents and fills in when there is a staff shortage. On 01/18/2024, Surveyor reviewed the community based residential facility (CBRF) registry. Surveyor observed MP G was not on the registry for fire safety, standard precautions and first aid and choking. On 01/22/2024 at 11:22 AM, Surveyor received an email that stated, "After searching all files, I did not find [his/her] certs [sic] from 2016. [MP G] is taking standard precautions class tomorrow. [MP G] will be taking the other classes as well. " The provider did not ensure 1 of 1 employee obtained all department approved training as required. Cross reference DHS 83.19 Orientation DHS 83.21(1)-(3) All Employee Training DHS 83.25 Continuing Education	N 239		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following:	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 243	Continued From page 17 Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment.	N 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 243	Continued From page 18	N 243		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 1 employee reviewed, obtained all training as required within 90 days after starting employment.

Managing Partner (MP) G did not have training in resident rights within 90 days after starting employment.

MP G did not have training in recognizing, preventing, managing and responding to challenging behaviors within 90 days after starting employment.

MP G did not have training in required client groups within 90 days after starting employment.

Findings include:

On 01/18/2024, Surveyor requested MP G's record from Administrator A. Administrator A stated s/he needed to have a sister facility send over MP G's employee file. Administrator A confirmed s/he was having trouble receiving MP G's employee file and s/he would send the information to Surveyor. Administrator A acknowledged MP G does work with residents and fills in when there is a staff shortage. On 01/22/2024 at 11:22 AM, Surveyor received an email that stated, "After searching all files, I did not find [his/her] certs [sic] from 2016."

Resident Rights

The record for MP G hired prior to 2016, did not have training in resident rights within 90 days after starting employment. There was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 243	Continued From page 19 documentation provided for MP G showing s/he had Resident Rights training within 90 days of hire. Recognizing, Preventing, Managing and Responding to Challenging Behaviors The record for MP G hired prior to 2016, did not have training in challenging behaviors within 90 days after starting employment. There was no documentation provided for MP G showing s/he had Recognizing, Preventing, Managing and Responding to Challenging Behaviors within 90 days of hire. Client Group The record for MP G hired prior to 2016, did not have client group training within 90 days after starting employment. There was no documentation provided for MP G showing they had Client Group training within 90 days of hire. The provider did not ensure MP G obtained all training as required within 90 days after starting employment. Cross reference DHS 83.19 Orientation DHS 83.20(2)(a)-(d) Department Approved Training Courses DHS 83.25 Continuing Education	N 243		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing	N 277		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 277	Continued From page 20	N 277		

education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following:
(1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure all resident care staff received continuing education which includes client group, resident rights, medications and fire safety and emergency procedures, for 1 of 1 staff (Managing Partner (MP) G).

This is a repeat deficiency. See Statement of Deficiency (SOD) OX9711, dated 04/23/2019.

Findings include:

The facility is licensed to provide services for up to 25 residents who may be terminally ill, advanced aged and/or irreversible dementia/Alzheimer's. The census at time of survey was 17.

On 01/18/2024 at 6:50 AM, Surveyor requested MP G's employee file from Administrator A. Administrator A stated s/he needed to have a sister facility send MP G's employee file over. Administrator A acknowledged MP G does work with residents and fills in when there is a staff shortage.

On 01/18/2024 at 11:43 AM, Surveyors

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 277	Continued From page 21 interviewed Licensee C. Licensee C stated s/he did not have MP G's employee file and was still waiting for sister facility to send. On 01/18/2024 at approximately 3:30 PM, Surveyor asked Administrator A if MP G's employee information was available. Administrator A stated s/he is having problems receiving and would send to Surveyor. On 01/22/2024 at 3:58 PM, Surveyor stated to Administrator A, "I am just confirming there is no record of [MP G's] continuing education?" Administrator A replied at 4:33 PM, "Yes that is correct." The provider did not ensure staff received the required continuing education training annually. Cross reference DHS 83.19 Orientation DHS 83.20(2)(a)-(d) Department Approved Training Courses DHS 83.21(1)-(3) All Employee Training	N 277		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 resident reviewed	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 22	N 352		

received prescribed medications in the dosage and intervals as prescribed.

This is a repeat deficiency. See Statement of Deficiency (SOD) S7O211, dated 01/25/2023.

Findings include:

On 01/17/2024 at approximately 10:00 AM, Surveyor reviewed Resident 4 and Resident 6's Medication Administration Record (MAR). Resident 4 was admitted to the facility on 02/16/2022 and Resident 6 was admitted to the facility on 09/14/2021.

Resident 4
Resident 4 had a physician order dated 12/22/2023, to debrox and flush after. Murine 6.5% Ear Drops - instill 2 drops each ear twice a day for 7 days then flush.

Surveyor reviewed Resident 4's December 2023 and January 2024 medication administration record (MAR), which showed Murine 6.5% Ear Drops at 8:00 AM and 8:00 PM. Resident 4 received ear drops on:

Resident 4's December MAR:

Date	8:00 AM	8:00 PM
12/22/2023	Blank	
	Administered	
12/23/2023	Administered	
	Administered	
12/24/2023	Administered	
	Administered	
12/25/2023	Administered	
	Administered	
12/26/2023	Administered	
	Administered	
12/27/2023	Administered	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 23	N 352		

Administered
12/28/2023 Administered
Administered
12/29/2023 Refused Refused

Review of Resident 4's record, no new order for ear drops was observed, however January MAR had the order Murine 6.5% Ear Drop - instill 2 drops each ear twice a day for 7 days then flush.

Resident 4's January MAR:

Date	8:00 AM	8:00 PM
01/01/2024	Refused	Refused
01/02/2024	Administered	
	Administered	
01/03/2024	Administered	
	Administered	
01/04/2024	Administered	
	Refused	
01/05/2024	Refused(not in med cart)	
	Administered	
01/06/2024	Administered	
	Refused	
01/07/2024	Administered	
	Administered	
01/08/2024	Refused (only 7 days)	
	Other (7 days)	
01/09/2024	Refused	Refused
(past 7 days)		
01/10/2024	Administered	
	Administered	
01/11/2024	Administered	
	Other (past 7 days)	
01/12/2024	Administered	
	Administered	
01/13/2024	Administered	
	Other (says use for 7 days starting 12/22/23)	
01/14/2024	Refused	Other
01/15/2024	Other (past 7 days)	
	Administered	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 24 01/16/2024 Administered Administered 01/17/2024 Administered Administered According to Resident 4's MAR, s/he had 20 doses of Murine 6.5% Ear Drops administered after the order had expired. Resident 4 had a physician order dated 11/24/2023 - 12/26/2023 and new order 12/26/2023 - with no expiration date - inhale 1 puff by mouth four time a day wheezing, shortness of breath. Surveyor reviewed Resident 4's December 2023 and January 2024 medication administration record (MAR), which showed Combivent Respimat Inhaler 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM: Resident 4's December MAR: Date 8:00 AM 12:00 PM 4:00 PM 8:00 PM 12/22/2023 Administered Administered Other (out) Refused 12/23/2023 Other (not in cart) Other (not in cart) Other (not here) Other (don't have it) 12/24/2023 Administered Administered Other (not here) Administered According to Resident 4's MAR, s/he did not receive Combivent Respimat Inhaler 5 times between 12/22/2023 and 12/24/2023, the reason documented in the MAR was out / not in cart / not here / don't have it. Resident 6 Resident 6 had an order for Bisacodyl 10 MG suppository - unwrap and insert 1 suppository	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 25 rectally weekly on Monday for constipation at 8:00 AM. 01/01/2024 Other 01/08/2024 Administered 01/15/2024 Other (not in med cart) On 01/18/2024 at 10:30 AM, Surveyor interviewed Manager B. Manager B provided Surveyor with the order dated 12/22/2023, for the ear drops for 7 days for Resident 4. Manager B acknowledged s/he did not have another order for the ear drops to be administered in January. Manager B was unsure about the Combivent Respimat Inhaler and had no comment. Manager B was unaware of Resident 6's Bisacodyl 10 MG suppository not administered on 01/01/2024 and 01/15/2024. Manager B acknowledged Surveyors findings. The provider did not ensure 2 of 2 residents reviewed received their medications as prescribed.	N 352		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review, observations and interviews, the provider did not ensure prompt and adequate treatment appropriate to the resident's needs was obtained for 6 of 6 residents	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 353	Continued From page 26 (Resident 1, Resident 5, Resident 7, Resident 8, Resident 9 and Resident 10). Interviews and observations reflected residents being left soiled, staff not responding to resident needs and concerns with the call system. Findings Include: On 01/18/2024 at 5:30 AM, Surveyor entered with Caregiver J. At 6:00 AM, Caregiver H and Surveyor toured and observed Resident 1 laying in his/her bed and s/he was wet. Caregiver H told Surveyor s/he needed to wait for a co-worker to change Resident 1. Surveyor and Caregiver H went to Resident 8's room and observed Resident 8 sitting in his/her recliner. Upon entering the room, the room had a strong odor of urine and Caregiver H acknowledged Resident 8's pants and pad were soaked through. On 01/18/2024 at 6:17 AM, Surveyor interviewed Caregiver J. Caregiver J stated s/he rounded every 4 hours on the night shift. On 01/18/2024 at 6:46 AM, Surveyor requested Resident 1 and Resident 8's ISP's from Manager B. Resident 1's ISP: Toileting - Resident Needs: To have staff initiate and assist with toileting schedule on an ongoing basis. Staff will cue as needed and assist when required Frequency of Service: 10 times every day and as needed Resident 8's ISP: Toileting - Resident Needs: Staff to monitor and cue resident to execute toileting on their own.	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 353	Continued From page 27 Physical assistance as needed to complete toileting. Resident does require frequent brief changes, this is to be fully performed by staff Frequency of Service: 10 times every day and as needed Note: Resident 8's ISP states 2 staff assistance with all transfers On 01/18/2024 at 8:40 AM, Surveyor asked what the expectation would be for frequency of service 10 times a day. Manager B stated residents would be checked every 2 - 3 hours. Manager B stated Resident 1 should be checked and changed every 2 - 3 hours on the night shift, and repositioned. Surveyor asked about Resident 8 being soaked through pants and pad. Manager B stated "[Caregiver J] most likely didn't change." Manager B stated that s/he knew Caregiver J won't change people even though Caregiver J knows s/he is supposed to, and only does parts of the job s/he wants to do. Manager B stated s/he knows it sounds bad, but s/he doesn't have anyone else and Administrator A hired him/her. Manager B confirmed Resident 1 and Resident 8 should be toileted every 2 - 3 hours. On 01/18/2024 at 9:55 AM, Surveyor interviewed Resident 9. Resident 9 had concerns staff do not always respond to the call light, especially at night, and s/he has to wait about an hour at times. Resident 9 had concerns with only 1 staff in the building over night. On 01/18/2024 at 11:43 AM, Surveyors interviewed Licensee C. Licensee C was unaware the call system was not working. Licensee C thought there was a new system ordered. Licensee C was unable to provide evidence a new call system was ordered and when a new system would be installed.	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 353	Continued From page 28 On 01/18/2024 at 12:45 PM, Surveyor interviewed Resident 10. Resident 10 stated his/her call light wasn't working. Staff tested and thinks it is working now. Resident 10 stated has to wait over an hour on the night time shift. On 01/18/2024 at 12:53 PM, Surveyor interviewed Resident 7. Resident 7 stated his/her call light hasn't been working. Resident 7 stated s/he has waits a long time for staff to respond and help. Resident 7 stated s/he has vision impairment and needs assistance. Resident 7 stated s/he has a phone and can call family or police if staff do not respond. On 01/18/2024 at 1:15 PM, Surveyors requested Resident 7's observation notes from Manager B. Resident 7's Observation Notes: 12/29/2023 - "Residents call light seems to be not working properly. [S/he] would like to be checked on throughout the night." 12/31/2023 - "Residents call bell is not working right again." 01/05/2024 - "Resident has caller 18 call light somehow, all though [sic] [him/hers] don't work". 01/11/2024 - "[S/he] is in a good mood however is upset that [his/her] call button isnt [sic] working that well. It was figured out that the call button is coming up as a different number all together and new people are not aware that it is [him/her] actually calling. No one was aware of this until this morning. New pager system was requested to Owner today for all residents as this one is very old and works when it wants too." On 01/18/2024 at 1:32 PM, Surveyors reviewed findings with Administrator A and Manager B. Administrator A took notes and Manager B listened. Administrator A and Manager B had no	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 353	Continued From page 29 comment for the concerns identified. Manager B stated no one knew that Resident 7 was given a pendant for #18. When #18 rang staff did not know who was ringing as that was an empty room. On 01/23/2024 at 12:30 PM, Surveyor interviewed Hospice M. Hospice M stated s/he was told by hospice staff that several of the residents were soiled, and they appeared to be soiled for a while. Hospice M stated the report s/he received was that Resident 1 was highly incontinent and s/he now has a "very red buttocks". Hospice M stated staff reports the pillows used to prop and reposition Resident 1 smelled like urine. Resident 5 does not self-transfer and s/he had a BM in the toilet and when hospice staff flushed the toilet, it overflowed. On 01/24/2024 at 9:30 AM, Surveyors exited with Licensee C and Licensee L. Licensee C stated s/he was unaware the call system was not working. Licensee C stated care concerns was unacceptable. Licensee C confirmed that Caregiver F told him/her that Resident 1 was wet when s/he came in. Resident 1 has a reddened area, s/he thinks from being wet, and is reaching out to the care team for additional information. The provider did not ensure prompt and adequate treatment appropriate to meet the resident's needs.	N 353		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written.	N 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 388	Continued From page 30	N 388		

This Rule is not met as evidenced by:
Based on record review, observation and interview, the provider did not ensure Individual Support Plans (ISP) were being implemented and followed as written for Resident 4.

Findings Include:

On 11/18/2023, at approximately 10:22AM, Surveyor interviewed Resident 4 in his/her room. Resident 4 informed Surveyor s/he would like to hear better. Surveyor observed a box for a pair of hearing aids sitting on Resident 4's dresser. Surveyor asked Resident 4 if s/he uses the hearing aids. Resident 4 informed Surveyor the hearing aids have not worked in months. Resident 4 stated s/he did not know why they were not working. With Resident 4's permission, Surveyor opened the box and observed a pair of unused hearing aids.

On 11/18/2023, at approximately 10:30AM, Surveyor reviewed Resident 4's Individual Support Plan (ISP) dated 09/11/2023. The ISP noted the following regarding hearing aids:

HEARING AIDS:
"AM & PM [Resident 4] needs assistance with putting on Hearing Aids [sic] and Removing [sic] them as well as charging. Daily."

On 11/18/2023 at approximately 1:30PM, Surveyor Interviewed Manager B regarding Resident 4's hearing aids. Manager B reported s/he recently received and email from Resident 4's Inclusa (Managed Care Organization) case manager about the hearing aids. Manager B was not able to confirm how long Resident 4's hearing aids were not functioning. Surveyor informed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 388	Continued From page 31 Manager B that Resident 4's ISP identified the need for assistance with his/her hearing aids. Manager B acknowledged understanding by stating, "Okay." No further information was provided prior to the survey exit.	N 388		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when 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 review and revise the individual service plan (ISP) annually or on change of condition for one (1) of 1 resident reviewed. This is a repeat deficiency. See Statement of Deficiency (SOD) 6DZK11, dated 06/07/2022. Findings include: On 01/18/2024, Surveyor toured the facility at 6:00 AM with Caregiver H and observed Resident 1 in bed. Caregiver H stated Resident 1 does not	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 389	Continued From page 32	N 389		

get out of bed. Resident 1 is bed bound and receives all cares in bed.

On 01/18/2024 at 6:45 AM, Surveyor requested Resident 1's ISP from Manager B. Surveyor reviewed Resident 1's ISP and observed the following:

Resident 1 was admitted to the facility on 04/27/2020. Resident 1's ISP had a report date of 01/18/2024, date of survey.

Resident 1's ISP reflected:

Mobility and Transferring - Requires full assistance including physical and verbal assistance with walking needs. Requires hand-on assistance with helping stand up, helping use any walking devices, and helping sit down/lay down. Resident goals - to independently and comfortably walk without walking device.

On 01/18/2024 at 8:40 AM, Surveyor interviewed Manager B. Manager B stated s/he started in December 2023 and Resident 1 was bed bound when s/he started. Manager B acknowledged s/he needs to update the ISPs, however s/he has not had time to update the ISPs yet. Manager B confirmed staff should be utilizing the ISP for resident needs and that they have hired 8 new staff in January 2024. Manager B asked Administrator A when Resident 1 had a change in condition and Administrator A stated s/he has been at the facility since July 2023, and Resident 1 was bed bound when s/he started. Administrator A confirmed s/he had Staff I input the ISP information from previous computer program into the new computer program. Administrator A confirmed Staff I did not assess residents or update the ISP's only transferred

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 389	Continued From page 33 information from the other computer system. The date the information was transferred showed in the computer. Administrator A was unable to tell Surveyors when the ISPs were due for the annual review. Administrator A stated s/he would see if they still had access to the other computer system to verify when the ISPs were due to be reviewed. Administrator A acknowledged the ISP for Resident 1 had not been updated to reflect Resident 1 was bed bound. On 01/18/2024 at 1:32 PM, Administrator A confirmed s/he did not have access to the dates the ISP's were last updated. Administrator A stated s/he could check with Licensee C to see if s/he could gain access to the original ISPs. Administrator A confirmed s/he did not have any signatures of who participated in the ISP's. The provider did not review and revise ISPs on changed of condition and were unable to tell Surveyors when the ISPs were due for the annual review.	N 389		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure injectable's, stomal and	N 416		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 416	Continued From page 34	N 416		

enteral medications, treatments or preparations delivered vaginally or rectally were administered by a registered nurse (RN), licensed practical nurse (LPN), or delegated to unlicensed caregivers for Resident 2, Resident 3, Resident 5 and Resident 6, pursuant to the Nurse Practice Act [s. N 6.03(3)] and in accordance with accepted standards of practice for 2 of 2 unlicensed caregivers (Caregiver D and Caregiver E) reviewed.

Findings include:

Chapter N6.03(3) is the Standard of Practice for RN's and addresses the supervision and direction of delegated tasks. The RN may delegate a task based on the educational preparation and demonstrated abilities of the person supervised but must provide direction and assistance, and observe, monitor, and evaluate the effectiveness of the delegated tasks.

On 01/18/2024, at 6:00 AM, Surveyor observed Caregiver D passing medications. Caregiver D confirmed s/he does the med pass including blood sugar checks and insulin. Caregiver D confirmed s/he had not received any nurse delegation, as there wasn't a nurse in the facility. Surveyor requested employee records and identified the following:

Caregiver D was hired on 01/15/2024. Caregiver D's file did not contain evidence of receiving RN delegation for administering injectable medications.

Caregiver E was hired on 01/10/2024. Caregiver E's file did not contain evidence of receiving RN delegation for administering injectable medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 416	Continued From page 35 On 01/18/2024 at 9:45 AM, Surveyor interviewed Administrator A and Manager B. Administrator A stated they are trying to find a new nurse. Administrator A confirmed they have not had a nurse since November 2023. Administrator A acknowledged Caregiver D is administering insulins and checking blood sugars. Administrator A confirmed Caregiver D had not received any nurse delegation. Administrator A stated they hired 8 new staff in January 2024, but they do not have a nurse to do the nurse delegation. On 01/18/2024 at 11:43 AM, Surveyors interviewed Licensee C. Licensee C was unaware the nurse had quit and that there was not a delegating nurse working in the facility. Licensee C inquired where the nurse went and why the nurse hadn't been replaced. Licensee C reviewed the staff roster and was unaware how many staff were newly hired since December 2023. Licensee C acknowledged s/he knew a nurse was required to delegate blood sugars, insulins and suppositories. On 01/18/2024 at approximately 1:32 PM, Surveyors interviewed Administrator A. Administrator A stated the nurse job was posted on indeed. Surveyors stated at the previous survey Administrator A stated there was a new nurse hired, what happened to that person. Administrator A stated that person never started. Administrator A confirmed the 8 new staff hired on the roster identified as med passers have not received any training or nurse delegation. On 01/18/2024 Surveyor reviewed resident records and observed the following:	N 416		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 416	Continued From page 36 Resident 2 was admitted on 04/23/201. Resident 2 requires blood sugars to be taken 4 times a day, orders for Lantus Solostar 36 units subcutaneously daily at bedtime, and Insulin Aspart Flexpen sliding scale 3 times a day at meals and as needed if blood sugar still greater than 400 in 2 hours. Resident 3 was admitted on 02/02/2023. Resident 3 requires blood sugars to be taken 4 times a day, before meals and at bedtime. Resident 3 has orders for Bisacodyl 10 MG Suppositories. Resident 5 was admitted on 02/01/2011. Resident 5 has orders for Acetaminophen suppository as needed and Bisacodyl suppository as needed. Review of Medication Administration Record (MAR), Resident 5 did receive a 10 MG Bisacodyl suppository on 01/08/2024. Resident 6 was admitted on 09/14/2021. Resident 6 has orders for Bisacodyl 10 MG Suppository, unwrap and insert 1 suppository rectally weekly on Mondays, and as needed order for Acetaminophen 650 MG Suppository every 6 hours as needed for pain or fever and Bisacodyl 10 MG as needed daily for constipation. Review of MAR's reflect Caregiver D and Caregiver E checked blood sugars and administered insulin. On 01/18/2024, Surveyor reviewed the facility folder, no waivers were received regarding nurse delegation. The provider did not ensure injectable medications, were delegated by a RN.	N 416		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 419	Continued From page 37	N 419		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and staff interview, the provider did not ensure 17 of 17 residents' medications were securely stored. Findings include: The facility is licensed to provide services for up to 25 residents who may be terminally ill, advanced aged and/or irreversible dementia/Alzheimer's. The census at time of survey was 17. On 01/18/2024, Surveyor entered the facility at approximately 5:30 AM. Surveyor observed the medication room with the door propped open and the medication cart unlocked at 5:36 AM. Surveyor walked around the facility for 10 - 15 minutes, before locating Caregiver J in Resident 3's room. Caregiver J was the only caregiver working. Surveyor observed at least 3 residents up with TV on upon arrival. Caregiver J was in Resident 3's room with the door closed and could not see the medication room or medication cart. On 01/18/2024 at approximately 5:50 AM, Surveyor interviewed Caregiver J. Caregiver J stated s/he had gone in the medication room to get medication for a resident. Caregiver J stated s/he was going to go back to the medication room after s/he had finished administering the medication, but Resident 3 had an incident and s/he was in his/her room and had not gotten back	N 419		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 419	Continued From page 38 to the medication room to lock the cart and door. Caregiver J stated s/he normally locks the cart and that staff leave the medication room door propped open. On 01/18/2024 at 6:46 AM, Surveyor interviewed Manager B. Manager B confirmed the medication room door and medication cart should be locked when staff are not in the medication room. Manager B stated s/he had gotten rid of staff for not following policy and procedures. Manager B acknowledged the medication cart should be locked at all times to keep the medications secured. The provider did not keep all medications locked/secured.	N 419		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving.	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 452	Continued From page 39 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored under sanitary conditions to prevent food borne illness. The provider did not properly seal and label open food. Findings include: The facility is licensed to provide services for up to 25 residents who may be terminally ill, advanced aged and/or irreversible dementia/Alzheimer's. The census at time of survey was 17. On 01/18/2024, at approximately 5:40 AM, Surveyors toured the kitchen/serving area. Surveyor observed the following items not sealed on shelving in pantry: - 12 oz box of oven ready Lasagna end of box open - 32 oz box of Spaghetti end of box open - 32 oz box of Buttermilk Light & Fluffy Complete Pancake Mix, dated 12-24, box tore open, open to air Kitchen - 2 ovens with black chunks burned in bottom of both ovens Kitchen Cabinet - 13 oz box of Animal Crackers, top of box open and bag open inside of box - 19.3 oz box Cinnamon Crunch Squares top of box open and bag open inside of box Kitchen Refrigerator: - Bowl of salad saran on top but not sealed	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 452	Continued From page 40 On 01/18/2024 at approximately 7:00 AM, Surveyors toured with Administrator A and Manager B. Surveyor shared observations with Administrator A and Manager B. Cook K was preparing breakfast and open box of Pancake mix was on the counter in the kitchen. Administrator A and Manager B acknowledged Surveyor's findings and Administrator A stated the items should be sealed and dated when opened. On 01/18/2024 at 7:30 AM, Surveyor interviewed Cook K. Cook K confirmed s/he had used the opened box of Pancake mix for breakfast. On 01/18/2024 at 1:10 PM, Surveyor returned to kitchen and observed the food items still open and unsealed. The "Servsafe Coursebook - 7th Edition" documents: Preventing Contamination from the Premises 3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. (Servsafe Coursebook, 7th Ed., 2017) The provider did not ensure food was stored to prevent food borne illness by properly sealing open food.	N 452		
N 637	83.59(1)(g) Proper exit locations, sidewalks, driveways. All habitable floors shall have at least 2 exits providing unobstructed travel to the outside.	N 637		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 637	Continued From page 41 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. Exits, sidewalks and driveways used for exiting shall be kept free of ice, snow, and obstructions. For facilities serving only ambulatory residents, the CBRF shall maintain a cleared pathway from all exterior doors to be used in an emergency to a public way or safe distance away from the building. For facilities serving semi-ambulatory and non-ambulatory residents, a CBRF shall maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2 primary exits from the building. All other required exits shall have at least a cleared pathway maintained to a public way or safe distance from the building. An exit door or walkway to a cleared driveway leading away from the CBRF also meets this requirement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that the outside driveway, sidewalk off the 2 side exits of the facility, back exit and walkways leading to the entrance of the facility were clear of ice/snow. Findings include: On 01/18/2024, Surveyor observed the physical environment. Surveyor observed the facility emergency exit sidewalks were full of ice and snow creating a slip/fall hazard. The sidewalks on the facility premises were not clear of ice and snow. There was an approximately 12" path shoveled around the building with approximately 6" of snow on the	N 637		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013617	A. BUILDING: _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARVINS MANOR IV	10 PLUIM DR WAUPUN, WI 53963

(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 637	Continued From page 42	N 637		

remainder of the sidewalks, and snow drifted across the shoveled areas with ice. The driveway on facility premises was not clear of ice and snow.

On 01/18/2024 at 11:43 AM, Surveyors interviewed Licensee C. Licensee C stated s/he had given Managing Partner (MP) G all the information on snow removal. Licensee C stated s/he is unsure who MP G has clear the snow. Licensee C acknowledged the sidewalks and driveway needs to be clear of snow and ice.

On 01/18/2024 approximately 3:30 PM, Surveyors discussed the above concern with Administrator A and Manager B. Neither Administrator A or Manager B commented, Administrator A was taking notes.

On 01/23/2024 at 12:30 PM, Surveyor interviewed Hospice M. Hospice M stated on 01/10/2024 when s/he was in the facility, s/he observed Licensee L ask Manager B about the driveway not being plowed and sidewalks not shoveled. Hospice M was unsure of the response Manager B provided.

According to Weather.gov January winter storm recap for 5 day estimated snowfall total map January 8, 2024 - January 13, 2024, for Waupun, WI was 12" - 18". Information was retrieved on 01/23/2024 at 8:32 AM, weather.gov/mkx/EarlyJanuary 2024_Recap.

The provider did not ensure that the outside driveway and sidewalks from exits were clear of ice/snow.