STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016901	A. BUILDING: _____ B. WING _____	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINWOOD MEMORY CARE	703 GREEM STREET BRODHEAD, WI 53520

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N 000	Initial Comments On 06/18/2024, Surveyor conducted a standard licensure survey at Collinwood Memory Care. Four deficiencies were identified. Two of 4 deficiencies were repeat violations. See Statement of Deficiency (SOD) BW3W11 and SOD BW3W12. Census: 11	N 000		
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 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 1 of 3 personnel files (Caregiver B) reviewed included a complete out-of-state background check as required. Findings include: On 06/18/2024, Surveyor reviewed Caregiver B's	N 219		

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

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N 219	Continued From page 1 record. Caregiver B was hired on 01/25/2024. Caregiver B's BID, dated 01/19/2024, documented that s/he had lived in Iowa from 2019 to 2021 and had received a felony during that time. Caregiver B's record contained a Wisconsin IBIS and a DOJ report, dated 01/24/2024; however, there was no documentation that the provider requested or received Caregiver B's DOJ report and Caregiver Registry report from the state of Iowa. On 06/18/2024, at approximately 12:30 PM, Surveyor interviewed Administrator A who verified there was no documentation of the Department of Justice report and the Caregiver Registry report for the state of Iowa.	N 219		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN	N 408		

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N 408	Continued From page 2	N 408		

psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that 2 of 3 residents prescribed PRN (as needed) psychotropic medication was documented in their Individualized Service Plan (ISP). The ISP did not include a rationale for use, nor a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication.

This is a repeat deficiency. See Statement of Deficiency (SOD) BW3W11, dated 05/10/2021, and BW3W12, dated 07/14/2021.

Resident 1's ISP did not identify s/he was on PRN Hydroxyzine or include a rationale for use, nor a detailed description of the behaviors, which indicate the need for administration.

Resident 2's ISP did not identify s/he was on PRN Lorazepam or include a rationale for use, nor a detailed description of the behaviors, which indicate the need for administration.

Findings include:

On 06/18/2024, Surveyor reviewed Resident 1's and Resident 2's record.

Example 1: Resident 1

Resident 1's May 2024 Medication Administration Record (MAR) documented:

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N 408	Continued From page 3 Hydroxyzine 10 MG (milligram) tablet - Take 1 tablet by mouth 3 times daily as needed for feeling anxious *prior to medical appointments* when s/he is feeling anxious. The PRN Hydroxyzine was administered on the following dates for the following reasons: 05/07 9:36 AM - Anxious 05/08 8:18 AM - Anxious and resident asked for it 05/15 9:20 AM - Anxious 05/16 10:59 AM - Anxious 05/28 8:51 AM - Anxious 05/29 9:27 AM - Feeling anxious about going out for labs Resident 1's ISP, dated 06/06/2024, documented: "Medications - Administered by staff." "Psychotropic Medications - Using scheduled psychotropic medications related to specific behaviors. Appropriate use of medications will be maintained. Resident to show no adverse effects related to psychotropic medication use. Resident behaviors to be controlled as allowed by progress of disease process. Staff to document use and document any refusals or adverse affects. Monthly blood draws for Clozapine by house RN (registered nurse) or lab in [medical clinic]." "Attitude - Supervise/intervene - Redirect negative attitudes. Notify appropriate provider (psychiatrist, doctor) when necessary. To receive complete assistance and care from staff redirecting negative attitudes." "Aggressive/Combative - Independent - Resident displays no aggressive/combative behaviors currently." Resident 1's "Observation" notes did not document concerns related to administering the PRN Hydroxyzine on the identified 05/2024 dates.	N 408		

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N 408	Continued From page 4 Example 2: Resident 2 Resident 2's February and March 2024 MAR documented: Lorazepam 0.5 MG tablet - Take 1 tablet by mouth 2 times daily as needed for anxiety. The PRN Lorazepam was administered on the following dates with no rationale documented: 02/17 10:39 AM, 02/19 2:07 PM, 02/21 2:41 AM, 03/02 2:21 PM, 03/21 6:47 PM Resident 2's ISP, dated 12/21/2023, documented: "Medications - Administered by staff." "Psychotropic Medications - Using psychotropic medications related to specific behaviors. ... Lorazepam 0.5MG is used as a PRN for anxiety. Appropriate use of medications will be maintained. Resident to show no adverse effects related to psychotropic medication use. Resident behaviors to be controlled as allowed by progress of disease process. Resident 2's "Observations" notes did not document concerns related to administering the PRN Lorazepam on the identified 02/2024 and 03/2024 dates. On 06/18/2024, at approximately 12:30 PM, Surveyor interviewed Administrator A. Administrator A stated s/he would review the resident ISPs to ensure the PRN medications were identified and the individuals behaviors identified as to when the PRN psychotropic medication should be administered.	N 408		
N 481	83.43(1) Environment safe, clean, and comfortable	N 481		

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N 481	Continued From page 5 Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a living environment that is clean, comfortable, and homelike. This is a repeat deficiency. See Statement of Deficiency (SOD) BW3W11, dated 05/10/2021. Findings include: The provider is licensed to care for a maximum of 11 residents within the client groups advanced aged, physically disabled, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, and terminally ill. On 06/18/2024, at approximately 11:00 AM, Surveyor toured the facility and detected a faint urine like scent. Surveyor sat down on a couch located in the common area and detected a stronger urine like scent. Surveyor also detected a urine like scent on the recliner chair next to the couch. On 06/18/2024, at approximately 12:00 PM, Surveyor interviewed Administrator A. Administrator A stated that the furniture throughout the facility had been cleaned several times but it may be time to replace the furniture.	N 481		

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N 499	Continued From page 6	N 499		
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 that cleaning compounds and toxic substances were stored in a secure area. Findings include: The provider is licensed to care for a maximum of 11 residents within the client groups advanced aged, physically disabled, irreversible dementia/Alzheimer's, emotionally disturbed/mental illness, and terminally ill. On 06/18/2024, at approximately 10:45 AM, Surveyor toured unsecured facility kitchen and observed the following: -A 32 fluid ounce bottle of foaming bleach bathroom cleaner -A 32 fluid ounce bottle of professional surface disinfectant -A 32 fluid ounce bottle of bathroom spray - lavender scent -A 15 ounce spray can of flying insect killer -A 19 ounce spray can of disinfectant spray - fresh linen scent -A 23 fluid ounce bottle of window cleaner -A 32 fluid ounce bottle of mildew destroyer -A 16 ounce spray can of oven cleaner On 06/18/2024, at approximately 11:45 AM, Surveyor requested assistance from	N 499		

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N 499	Continued From page 7 Administrator A in the med room. Administrator A asked Surveyor if s/he could wait until the other staff member was available as residents were sitting in the dining room and needed to be supervised. On 06/18/2024, at approximately 10:30 AM, Surveyor interviewed Administrator A. Administrator A stated there was a side door to the kitchen area that was always locked but would discuss the main door being locked as well with staff. Administrator A agreed that the residents needed to be supervised and could quickly ambulate into the section of the kitchen where the cleaning supplies were unsecured.	N 499		