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KINDREDHEARTS OF ELKHORN	450 E GENEVA ST ELKHORN, WI 53121

(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 07/10/2024, with information obtained through 07/12/2024, the Bureau of Assisted Living, Southern Regional Office, conducted a verification visit and complaint investigation at Kindredhearts of Elkhorn, a community-based residential facility (CBRF) located in Elkhorn, WI. As a result of the survey, 7 deficiencies were identified. Three deficiencies are repeat deficiencies. See Statement of Deficiency (SOD) FTUV12, dated 02/02/2024. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. The complaint was unsubstantiated. Census: 17	N 000		
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	N 239		

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

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N 239	Continued From page 1 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 record review and interview, the provider did not ensure that 3 of 4 employees reviewed obtained all department approved training as required. Caregiver E did not have training in fire safety or first aid and choking within 90 days after starting employment. Caregiver F and Caregiver G, who both had responsibilities that would create exposure to blood, body fluids, or other moist body substances, did not have training in standard precautions prior to assuming these duties. This is a repeat deficiency. See Statement of Deficiency (SOD) FTUV12, dated 02/02/2024. Findings include: On 07/10/2024, Surveyor conducted a review of 4 employees to verify compliance with department approved training requirements. Surveyor requested records from Resident Director H for Caregivers E, F, and G. Fire Safety	N 239		

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N 239	Continued From page 2 The record for Caregiver E, hired 03/10/2024, did not contain evidence of training or evidence of meeting an exemption for fire safety. On 07/10/2024, at approximately 1:47 p.m., Surveyor interviewed Resident Director H. Resident Director H confirmed the provider did not have evidence that Caregiver E completed or met an exemption for fire safety training. On 07/10/2024, Surveyor verified Caregiver E was not on the Community-Based Care and Treatment training registry for fire safety. First Aid and Choking The record for Caregiver E, hired 03/10/2024, did not contain evidence of training or evidence of meeting an exemption for first aid and choking. On 07/10/2024, at approximately 1:47 p.m., Surveyor interviewed Resident Director H. Resident Director H confirmed the provider did not have evidence that Caregiver E completed or met an exemption for first aid and choking training. On 07/10/2024, Surveyor verified Caregiver E was not on the Community-Based Care and Treatment training registry for first aid and choking. Standard Precautions On 07/10/2024, at approximately 8:50 a.m., Surveyor encountered a staff member who identified him/herself as Caregiver F, and reported s/he was a caregiver working that day. Caregiver F reported that s/he had been working as a caregiver with the provider since May 2024 (approximately 2 months).	N 239		

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N 239	Continued From page 3 At approximately 12:34 p.m., Surveyor interviewed Resident Director H about staff duties. Resident Director H confirmed that Caregiver G was a caregiver who had responsibilities for conducting resident cares. Resident Director H confirmed that Caregivers F and G perform job tasks that may expose them to blood or other body fluids. The records for Caregiver F, hired 05/20/2024, and Caregiver G, hired 05/12/2024, did not contain evidence of training or evidence of meeting an exemption for standard precautions. On 07/10/2024, at approximately 1:47 p.m., Surveyor interviewed Resident Director H again. Resident Director H confirmed the provider did not have evidence that Caregivers F and G completed or met an exemption for standard precautions training prior to assuming these job duties. At approximately 1:53 p.m., Surveyor interviewed Caregiver F, with Resident Director H present. Caregiver F reported s/he had watched some videos as part of his/her initial training but was unable to recall specific training content. Resident Director H confirmed that this sounded more like company-specific training and not the training format of the department-approved standard precautions training. On 07/10/2024, Surveyor verified Caregivers F and G were not on the Community-Based Care and Treatment training registry for standard precautions.	N 239		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in	N 310		

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N 310	Continued From page 4 writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 9's admission agreement was signed, that there was an	N 310		

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admission agreement for Former Resident 7, or that the admission agreements for Residents 6, 8, and 9 contained correct information regarding the facility, state's advocacy groups, resident rights, and refunds.

This is a repeat deficiency. See Statement of Deficiency (SOD) FTUV12, dated 02/02/2024.

Findings include:

Example 1 - Current information

On 07/10/2024, Surveyor reviewed Department records for the provider. The provider's records indicated that the current licensed facility was owned by Company L. No pending changes of ownership for the facility were observed in the Department records. An e-mail in the provider's record, dated 02/16/2024, documented a notification of "a change in management of operations" for Kindredhearts of Elkhorn. The e-mail identified that Company M "will be the new management company" and that Company M has owned and operated several assisted living facilities in an adjacent state.

Surveyor then reviewed the signed admission agreements for Residents 6, 8, and 9. The admission agreements for all 3 documented on the first page: "Establishment Owner: [Company M]" and provided Company M's mailing address. Underneath that, the following was documented: "Community Full Address:..." The address listed was for a separately licensed community-based residential facility (CBRF) located in a different city of the state.

The first page of the agreement documented, "This agreement is between [Company M] and,

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N 310	Continued From page 6 (RESIDENT NAME) hereafter referred to as [Company M initials] Resident, and hereafter referred to as Responsible Party, who,...do hereby agree to be bound by the following terms, conditions and arrangements regarding the provision of Assistance Services to Family Member. [Company M] is licensed as a Shared Housing Establishment by the [adjacent state] Department of Public Health." The entire 12 page admission agreement documented terms in conjunction with Company M. There was no information about Company L or "Kindredhearts of Elkhorn" in any of the admission agreements. Under the "Complaint Resolution Process" section of the admission agreements, the following advocacy information was documented: "The Resident may request assistance with complaint resolution from [adjacent state] Department on Aging Helpline or the Long Term Care Ombudsman. [Adjacent state] Department of Aging Senior Helpline #--- [phone number]. Long Term Care County Ombudsman #--- [specific ombudsman's name and phone number]." Upon Surveyor's further investigation, the name and phone number listed for the ombudsman were linked on a website for a company whose services were documented as being located in the same adjacent state as listed elsewhere in the agreement. There was no information regarding resident advocacy groups that served clients in Wisconsin, including the ombudsman program located in Wisconsin or Disability Rights Wisconsin, Inc. Under the "Resident Rights" section of the admission agreements, the following was documented: "According to Section [statute number] Resident Rights include..." The rights listed were not the resident rights as defined by	N 310		

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N 310	Continued From page 7 Wis. Admin Code § DHS 83.32(3). Upon Surveyor's further investigation, the administrative code listed in the admission agreement was for administrative code of an adjacent state (the same state as referenced elsewhere in the agreement), which identified resident rights of assisted living residents in that state. Upon comparison of the that state's rights listed from the administrative code in the agreement and Wis. Admin Code § DHS 83.32(3), the following rights were not documented in the agreements: - Rights under Wis. Admin Code § DHS 83.32(3)(a) (Communications) - Information regarding the right to be free from misappropriation of property, as under Wis. Admin Code § DHS 83.32(3)(d) (Freedom from Mistreatment) - Rights under Wis. Admin Code § DHS 83.32(3)(e) (Freedom from Seclusion) - Rights under Wis. Admin Code § DHS 83.32(3)(h) (Receive Medication) - Rights under Wis. Admin Code § DHS 83.32(3)(i) (Prompt and Adequate Treatment) - Rights under Wis. Admin Code § DHS 83.32(3)(L) (Least Restrictive Environment) - Rights under Wis. Admin Code § DHS 83.32(3)(m) (Recording, Filming, Photographing) - Rights under Wis. Admin Code § DHS 83.32(3)(n) (Safe Environment) One section of the admission agreements documented, "[Adjacent state] DEPARTMENT OF PUBLIC HEALTH [state agency initials] shall conduct an annual, unannounced on-site review of the establishment to determine compliance with the applicable licensure requirements and standards...During an on-site review, [adjacent state's public health department] may tour any area of the establishment, observe residents and	N 310		

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staff,...[and] inspect the resident's clinical and administrative records with the resident's written consent..."

A section titled "Refund PROCEDURE" documented that any refunds were to be issued to responsible parties "within 60-90 days following the removal of the [Company M initials] Resident from [Company M]." Surveyor observed that this information conflicted with Wis. Admin Code § DHS 83.29(3)(a), which directs that "The CBRF shall return all refunds due a resident under the terms of the admission agreement within 30 days after the date of discharge." According to Wis. Admin Code § DHS 83.29(4), "No statement of the admission agreement may be in conflict with any part of this chapter, unless the department has granted a waiver or variance of a provision of this chapter." Upon reviewing the Department's records for the provider again, Surveyor did not observe any waiver granted from the Department that allowed Company M to return funds in 60-90 days as opposed to 30 days after a resident's discharge.

While reviewing the above agreements, at approximately 1:15 p.m., Surveyor interviewed Resident Director H. Resident Director H acknowledged Surveyor's concern that the admission agreements had inconsistent information regarding the owner and facility, as well as incorrect information regarding relevant rights, advocacy groups, and refund terms. Resident Director H reported that it was his/her second day on the job and that the admission agreements had all been completed prior to his/her employment, so s/he wasn't sure why the information was like that.

Example 2 - Former Resident 7's admission

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agreement

On 07/10/2024, at approximately 10:24 a.m., Surveyor requested the signed admission agreement for Former Resident 7 from Resident Director H. Former Resident 7 was admitted to the provider on 01/15/2021 until his/her discharge on 05/30/2024.

At approximately 12:10 p.m., Surveyor interviewed Resident Director H. Resident Director H reported s/he was unable to find Former Resident 7's admission agreement.

At approximately 1:10 p.m., Surveyor interviewed Resident Director H again. Resident Director H reported that s/he had texted Administrator K, who was out of the office, asking where admission agreements would be located and that Administrator K replied that the previous operators "have not turned everything over." Surveyor asked Resident Director H what this specifically meant. Resident Director H replied s/he wasn't sure.

At approximately 2:23 a.m., Surveyor interviewed Resident Director H again. Resident Director H reported that s/he still was not able to locate Former Resident 7's admission agreement. Surveyor gave a deadline of 12:00 p.m. on 07/11/2024 for the agreement to be sent.

No further records were received.

Example 3 - Resident 9's signed admission agreement

On 07/10/2024, Surveyor reviewed Resident 9's record. Resident 9 was admitted to the provider on 03/27/2024. Resident 9 was documented as

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having an activated power of attorney for healthcare (POA). Resident 9 was documented as having contracted services through a managed care organization. Surveyor reviewed Resident 9's admission agreement, which was signed by him/her and dated 03/27/2024. There was no evidence of Resident 9's legal representative having reviewed or signed the admission agreement. Surveyor did not see any POA paperwork as part of Resident 9's record.

At approximately 1:26 p.m., Surveyor interviewed Resident Director H. Resident Director H reported s/he was unable to find any POA paperwork for Resident 9 and was unable to verify whether Resident 9's POA was activated prior to or after his/her admission.

At approximately 2:23 a.m., Surveyor interviewed Resident Director H again. Resident Director H reported that s/he still was not able to locate POA paperwork for Resident 9. Surveyor gave a deadline of 12:00 p.m. on 07/11/2024 for any information to be sent.

On 07/11/2024, at approximately 11:19 a.m., Resident Director H reported that s/he had contacted Resident 9's case manager in order to obtain his/her POA paperwork, and that the case manager was supposed to be sending it later that day.

On 07/12/2024, at approximately 10:20 a.m., Surveyor interviewed POA N, the power of attorney for healthcare for Resident 9. POA N reported that s/he had been the activated POA for Resident 9 since 2022 (prior to Resident 9's admission to the facility). POA N reported that when Resident 9 admitted to the provider, Former Administrator A told him/her that s/he would send

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N 310	Continued From page 11 Resident 9's admission agreement for him/her to review but that s/he never received it. Former Administrator A reported that new management had taken over sometime around the time Resident 9 admitted to the provider and no one had reached out to him/her since or provided any contact. POA N reported that s/he thought this was weird.	N 310		
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 ensure that the individual service plan (ISP) for 3 of 3 residents reviewed was updated when there were changes in their needs and abilities. There was no information in the ISPs for Residents 3 and 4 about their bed alarm use. There was no information in Former Resident 7's ISP about his/her bed and chair alarm use.	N 389		

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Resident 4's ISP was not updated to reflect his/her change in mobility or his/her physical therapy services.

Findings include:

Example 1 - Resident 3

On 07/10/2024, at approximately 10:02 a.m., Surveyor interviewed Caregiver I regarding resident needs. Caregiver I reported that staff used bed alarms for both Residents 3 and 4 due to their fall risk.

At approximately 2:11 p.m., Surveyor observed Resident 3's bed alarm in place at his/her bed.

On 07/10/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 12/01/2022. Resident 3's current ISP, not dated and provided by Resident Director H, did not include any information about his/her bed alarm use.

On 07/10/2024, at approximately 2:23 p.m., Surveyor interviewed Resident Director H. Resident Director H reported that it was his/her second day on the job as the resident director. Resident Director H acknowledged Surveyor's concern that bed alarm use was not noted in Resident 3's ISP.

Example 2 - Resident 4

On 07/10/2024, at approximately 10:02 a.m., Surveyor interviewed Caregiver I regarding resident needs. Caregiver I reported that staff used bed alarms for both Residents 3 and 4 due to their fall risk.

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N 389	Continued From page 13 At approximately 11:47 a.m., Surveyor observed Caregiver I conducting cares with Resident 4. Caregiver I showed Surveyor the bed alarm that was used for him/her. Caregiver I reported that staff had used a bed alarm with Resident 4 for almost the past year. During cares, Surveyor observed Caregiver I assist in transferring Resident 4 from the toilet to a manual wheelchair. Caregiver I then pushed Resident 4's wheelchair from his/her bathroom out to the dining area in preparation for lunch. Caregiver I reported that Resident 4 used to use a walker for ambulation but about a month ago was having difficulty with one of his/her hands not being able to grip the walker, making it unsafe for use. Caregiver I reported that because of this, Resident 4 had relied for the last month on staff pushing him/her around in a manual wheelchair for all mobility. On 07/10/2024, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 08/19/2021. Resident 4's current ISP, not dated and provided by Resident Director H, did not include any information about his/her bed alarm use. Under the "Physical Disabilities - Ambulation" section of the ISP, the following was documented: "...requires the following safety measures: CONTACT GUARD ASSIST hold on gait belt always. 2 wheel rolling walker, gait belt and when outside room trail with wheelchair when walking..." There was no updated information about Resident 4 using a wheelchair for mobility needs. On 07/10/2024, at approximately 2:23 p.m., Surveyor interviewed Resident Director H. Resident Director H reported that it was his/her second day on the job as the resident director. Resident Director H acknowledged Surveyor's	N 389		

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concern that bed alarm use was not noted in Resident 4's ISP. Regarding Resident 4's ambulation, Resident Director H confirmed the details provided by Caregiver I earlier and confirmed that Resident 4 was no longer using a walker for mobility. Resident Director H reported that Resident 4 had been working with physical therapy 1-2 times each week for approximately the last 2 months, and that Resident 4's physical therapy team was looking at possibly attempting future use of a specific type of walker that could accommodate her lack of unilateral grip. During the interview, Surveyor reviewed Resident 4's ISP again. There was one line under the "General Task" section, dated 06/19/2024, that documented, "Per PT, offer ice pack for arm pain..." but no other information regarding Resident 4's physical therapy services.

Example 3 - Former Resident 7

On 07/10/2024, at approximately 10:02 a.m., Surveyor interviewed Caregiver I regarding resident needs. Caregiver I reported that staff had used a bed and chair alarm for Former Resident 7 for at least a few months prior to his/her discharge from the provider due to him/her experiencing falls.

On 07/10/2024, Surveyor reviewed the closed record for Former Resident 7, who was admitted to the provider on 01/15/2021 and discharged on 05/30/2024. Surveyor reviewed Former Resident 7's observation notes from 03/01/2024 through his/her discharge on 05/30/2024. An entry on 05/16/2024, at approximately 10:45 p.m., documented a fall out of bed that Former Resident 7 experienced. Former Resident 7's ISP active at the time of his/her discharge, not dated and provided by Resident Director H, did not

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N 389	Continued From page 15 include any information about a bed alarm or chair alarm use. Under the ISP heading "Falls Management", which was dated 03/23/2023, the following was documented: "...Resident has history of falling..." On 07/10/2024, at approximately 2:23 p.m., Surveyor interviewed Resident Director H. Resident Director H reported that it was his/her second day on the job as the resident director. Resident Director H acknowledged Surveyor's concern that bed and chair alarm use was not noted in Former Resident 7's ISP. On 07/12/2024, at approximately 8:55 a.m., Surveyor interviewed Family Member J, who was the activated power of attorney for healthcare for Former Resident 7. Family Member J confirmed that staff had been using both a bed and chair alarm for Former Resident 7 due to his/her history of falls but that s/he had concerns they were not being consistently used when Former Resident 7 lived with the provider.	N 389		
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,	N 408		

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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 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 the individual service plans (ISPs) for Residents 3, 4, and 5 included a rationale for use and detailed description of the behaviors which indicated the need for administration of as-needed (PRN) Lorazepam for Residents 3 and 5 and PRN Hydroxyzine for Resident 4.

This is a repeat deficiency. See Statement of Deficiency (SOD) FTUV12, dated 02/02/2024.

Findings include:

On 07/10/2024, at approximately 10:00 a.m., Surveyor reviewed the provider's 2 medication carts with Caregiver I. Surveyor observed the following PRN psychotropic medications:

- 1 card of Lorazepam 0.5 mg tablets. The pharmacy label on the card documented that it was prescribed to Resident 3 and that 30 tablets within the card were dispensed on 05/17/2023. One tablet was observed punched out. The prescription instructed to, "Take 1 tablet by mouth every 2 hours as needed for mild-moderate anxiety/restlessness/nausea." Caregiver I confirmed that this was still a current medication for Resident 3 and was part of a comfort pack

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N 408	Continued From page 17 from his/her hospice agency. - 1 card of Hydroxyzine HCl 10 mg tablets. The pharmacy label on the card documented that it was prescribed to Resident 4 and that 30 tablets within the card were dispensed on 04/12/2024. All tablets were observed within the card. The prescription instructed to, "Take 1 tablet by mouth every 6 hours as needed for anxiety. (Anxiety/insomnia)." - 1 card of Lorazepam 0.5 mg tablets. The pharmacy label on the card documented that it was prescribed to Resident 5 and that 20 tablets within the card were dispensed on 06/14/2024. All tablets were observed within the card. The prescription instructed to, "Take 1-2 tablets (0.5 - 1 mg) by mouth every 2 hours as needed for anxiety, 1-mild, 2-moderate. Take only when directed by nurse, for emergency use only." On 07/10/2024, Surveyor reviewed the facesheets and current ISPs for Residents 3, 4, and 5, provided by Resident Director H. The facesheet for Resident 3, which included his/her medication list, documented that his/her PRN Lorazepam was a current medication. The ISP for Resident 3, not dated, did not contain any information regarding his/her PRN Lorazepam. The facesheet for Resident 4, which included his/her medication list, documented that his/her PRN Hydroxyzine was a current medication. The ISP for Resident 4, not dated, did not contain any information regarding his/her PRN Hydroxyzine. The facesheet for Resident 5, which included his/her medication list, documented that his/her PRN Lorazepam was a current medication. The ISP for Resident 5, not dated, did not contain any information regarding his/her PRN Lorazepam.	N 408		

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N 408	Continued From page 18 At approximately 2:23 p.m., Surveyor interviewed Resident Director H. Resident Director H confirmed that there were no rationales for use or detailed descriptions of the behaviors warranting the use of PRN Lorazepam for Residents 3 and 5 or PRN Hydroxyzine for Resident 4, located within their ISPs.	N 408		
N 425	83.38(1)(a) Personal care. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure personal care services for Resident 3 were provided adequate to meet his/her needs. Resident 3 was unattended on the toilet for at least 31 minutes, despite staff interview identifying that s/he should have been directly supervised due to his/her fall risk and inability to	N 425		

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use his/her call light reliably. Resident 3 was transferred 3 times by staff with an under-arm "hugging" technique as opposed to using a gait belt, which was directed to be used in his/her ISP. After the second transfer, Resident 3 was observed with behaviors consistent with experiencing right upper extremity discomfort or pain. At approximately 11:19 a.m., Surveyor attempted to interview Resident 3 to ask about his/her arm, but was unable to do so due to Resident 3 reporting an inability to hear Surveyor. Per staff interview, Resident 3 typically wore a hearing aid which should have been put in during his/her morning cares but was not in that morning. At approximately 12:02 p.m., after Resident 3 had returned to his/her room from eating lunch in the dining area with other residents, his/her hearing aid was still not put in.

Findings include:

On 07/10/2024, at approximately 10:02 a.m., Surveyor interviewed Caregiver I. In discussing bed and chair alarm uses, Caregiver I reported that Resident 3 was a resident who utilized a bed alarm. Caregiver I reported that this was due to his/her fall risk.

At 10:32 a.m., Surveyor entered Resident 3's room in attempts to interview him/her. Resident 3 was observed sitting on the toilet located within his/her bathroom (not visible from the entryway of his/her room doorway). Side grab bars were observed on either side of the toilet. Surveyor waited outside Resident 3's room until 11:03 a.m. (31 minutes later), when Caregiver I entered Resident 3's room and assisted him/her in toileting cares. Between 10:32 a.m. and 11:03 a.m., no staff were observed checking in on Resident 3. During this timeframe, Resident 3

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was heard on occasion quietly calling out undistinguishable words. During this timeframe, Surveyor observed Caregiver I preparing lunch in the kitchen and Caregiver F walking Resident 6's dog within the facility. No other care staff were observed working.

After observing Caregiver I conduct toileting cares with Resident 3, Surveyor observed Caregiver I assist Resident 3 in lowering him/her from a standing position to seated in his/her wheelchair. No gait belt was observed on Resident 3 to assist with the transfer. After pushing Resident 3's wheelchair towards his/her recliner, Caregiver I transferred him/her from the wheelchair to his/her recliner. In conducting the transfer, Caregiver I was observed assisting Resident 3 with his/her arms under Resident 3's arms in a hugging position. No gait belt was used during the transfer. After Resident 3 was seated in his/her recliner, s/he was observed to grimace and alternate between holding and rubbing his/her right upper arm - behaviors that appeared consistent with experiencing discomfort or pain.

At approximately 11:19 a.m., Surveyor attempted to interview Resident 3 about his/her arm. Resident 3 repeatedly reported to Surveyor that s/he was unable to hear him/her. Resident 3 was not observed to have any hearing aids in. Surveyor then interviewed Caregiver I, who was back in the kitchen preparing lunch. Caregiver I confirmed that Resident 3 typically wore a hearing aid but that it hadn't yet been put in that day.

At approximately 12:02 p.m., Surveyor observed Caregiver F take Resident 3 from the dining area where s/he ate lunch with the other residents back to his/her room. Surveyor then observed Caregiver F transfer Resident 3 from his/her

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wheelchair to his/her recliner. In conducting the transfer, Caregiver F was observed assisting Resident 3 with his/her arms under Resident 3's arms in a hugging position. No gait belt was used during the transfer. After the transfer, Surveyor asked Caregiver F if Resident 3 had his/her hearing aid in yet. Caregiver F confirmed that Resident 3's hearing aid wasn't in yet and that s/he didn't know where it was. Caregiver F thanked Surveyor for the reminder about Resident 3's hearing aid. Caregiver F reported that typically whoever does morning cares puts hearing aids in for residents, but that the caregiver who assisted Resident 3 that morning must have forgotten to put his/hers in.

On 07/10/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 12/01/2022. Resident 3 was documented as receiving hospice services. Resident 3's current individual service plan (ISP), provided by Resident Director H, was not dated but included dates that individual components were added or revised within it. In reviewing Resident 3's ISP, Surveyor observed the following:

- Under the "Falls Management" heading, dated 06/03/2023: "Resident rarely falls (6 times or less per year) and requires the following safety measures: Resident requires assistance from 1 staff with gait belt to transfer..."

- Under the "Physical Disabilities - Transferring" heading, dated 06/02/2023: "Impaired physical mobility. Resident requires assistance from 1 staff with gait belt to transfer..."

- No information regarding his/her hearing aid use

- Under the "Toileting" section, dated 11/28/2022

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(over 1.5 years from the day of review): "...Resident requires at times needs assistance but is independent in toileting needs when up during the day..."

Resident 3's facesheet documented an activity instruction for staff to take his/her left hearing aid out at the 8:00 p.m. medication pass and put in at 7:00 a.m. The instruction also documented: "Hearing Aid Left only and DEAF in Right ear."

At approximately 2:23 p.m., Surveyor interviewed Resident Director H. Resident Director H confirmed that Resident 3 typically uses 1 hearing aid, which should typically be put in when morning staff were getting him/her ready for the day. Resident Director H acknowledged Surveyor's concern that without Resident 3's hearing aid in, in addition to his/her hearing concerns, that his/her communication with others was limited, such as during Surveyor's earlier attempt to interview him/her. When Surveyor reviewed his/her earlier observation of Resident 3 unattended for at least 31 minutes on the toilet, Resident Director H reported that staff should not have left Resident 3 alone at all while s/he was being toileted due to him/her being at risk for falling. Resident Director H reported that Resident 3 was known to not reliably use a call light, which is also why staff should have been supervising him/her. Resident Director H reported that this information should have been in Resident 3's ISP but acknowledged Surveyor's concern that it was not. Regarding Resident 3's transfers observed by Surveyor, Resident Director H confirmed that staff should have been using a gait belt, as directed in his/her ISP, while assisting Resident 3.

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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. This Rule is not met as evidenced by: Based on observation and interview, the CBRF did not prepare and serve food under sanitary conditions for the prevention of food borne illnesses. Findings include: According to the Wisconsin Department of Agriculture, Trade and Consumer Protection (WI DATCP), "Employees can prevent foodborne illness by practicing good personal hygiene. This includes proper handwashing...[and] wearing hair restraints and proper clothing." Specific guidance documents that hands should be washed in a wash sink for a minimum of 20 seconds using	N 452		

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soap, and that food employees "are required to wear hair restraints such as hair nets...that are effective in keeping hair under control," (Source: WI DATCP, Wisconsin Food Code Fact Sheet: Employee Hygiene and Cleanliness, November 2020, https://datcp.wi.gov/Documents/EmployeeHygieneFactSheet.pdf (retrieval date - July 12, 2024).).

On 07/10/2024, at approximately 10:22 a.m., Surveyor toured the food supply located in the provider's kitchen. Caregiver I was present. Surveyor asked Caregiver I if s/he wanted Surveyor to wear a hair net while walking through the kitchen and observing the food storage and preparation areas. Caregiver I replied, "Usually we don't have hair nets on hand."

At approximately 11:14 a.m., Surveyor observed Caregivers F and I preparing lunch for residents. Caregiver I was observed opening cans of food and prepping it in the kitchen. Caregiver I was then observed leaving the kitchen area and walking to the area of resident bedrooms (out of Surveyor's sight). Approximately 2 minutes later, Caregiver I returned to the kitchen, donned a pair of gloves, and began preparing vegetables. No hand hygiene was observed between Caregiver I's activities. Caregiver I, whose hair length was approximately just below his/her ears at its longest, was not observed wearing a hair net during any food preparation activities.

At approximately 12:00 p.m., Surveyor observed Caregiver F walking around the kitchen. Caregiver F then entered the dining area and assisted Resident 5, who was seated in a wheelchair, to the table. Caregiver F then walked back to the kitchen and was observed rubbing his/her nose. Caregiver F then retrieved a pitcher

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N 452	Continued From page 25 of juice from the kitchen and poured a cup of juice at the table for Resident 5. No hand hygiene was observed during this process. Caregiver F, who had hair in a ponytail with the ends down to approximately his/her shoulder, was not observed wearing a hair net while assisting in the kitchen. At approximately 2:23 p.m., Surveyor interviewed Resident Director H. Resident Director H reported that the lack of hygiene observed by Surveyor was "gross." Resident Director H reported that s/he had previously worked as a caregiver with the provider and that s/he didn't recall there ever being hair nets available for staff to wear while conducting food preparation duties.	N 452		
N 491	83.44(2)(c) Interior floors, walls and ceilings. Every interior floor, wall and ceiling shall be clean and in good repair. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that the dining area floors were clean and in good repair. Findings include: On 07/10/2024, at approximately 9:15 a.m., Surveyor reviewed the facility's dining area. Surveyor observed 3 separate sections, 1 measuring approximately 3' x 6', 1 measuring approximately 2' x 4', and 1 measuring approximately 2' x 3', that all appeared to be covered in multiple black marks (Photos 1, 2, and 3). On 07/12/2024, at approximately 12:30 p.m.,	N 491		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF ELKHORN	450 E GENEVA ST ELKHORN, WI 53121

(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 491	Continued From page 26 Surveyor interviewed Resident Director H. Resident Director H reported s/he was aware of the marks on the dining area flooring. Resident Director H that approximately 1 month ago new owners bought the facility from the old owners and were looking to get a loan for building repairs.	N 491		