STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014097	A. BUILDING: _____ B. WING _____	R-C 02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON PLACE MEMORY CARE 3	3902 EAST ROTAMER ROAD JANESVILLE, WI 53546

(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 02/04/2025, Surveyor conducted a standard survey and verification visit at Huntington Place Memory Care 3. Five deficiencies were identified. Three of 5 deficiencies were repeat violations. See Statements of Deficiency (SOD) FV3E11, dated 10/03/2024, SOD 98QK11, dated 06/05/2023, SOD Q6TG12, dated 02/24/2020, and SOD Q6TG11, dated 08/12/20219. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 15	{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 provider did not ensure the CBRF and its operation comply with all laws governing the CBRF. The provider did not comply with the special orders outlined in a Notice and Order letter sent by the Department on 10/31/2024. The facility is licensed to serve up to 25 residents in the client groups of irreversible dementia/Alzheimer's and advanced age. Findings include:	N 196		

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

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N 196	Continued From page 1 On 02/04/2025, Surveyor reviewed Department records and identified the following: On 10/31/2024, Statement of Deficiency (SOD) FV3E11 and a Notice and Order letter were issued to the licensee. The Notice and Order letter included the following information under SPECIAL ORDERS: "2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide the legal representative and case manager (if any) for each resident with a copy of Statement of Deficiency FV3E11 and a copy of this Notice and Order letter. The licensee shall retain documentation, acceptable to the department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from each legal representative and case manager. The documentation required by Order #2 will be available to department representatives upon request. On 02/04/2025 at 12:45 PM, Surveyor requested evidence the provider followed Order #2 from Regional Nurse P. On 02/04/2025 at 2:10 PM, Surveyor conducted an exit conference and shared findings with Interim Administrator N, Administrator O, and Regional Nurse P. Regional Nurse P reported the provider did not complete the 2nd special order within SOD FV3E11. Regional Nurse P noted the no new admit order was followed, the provider hired a dietician consultant, and retraining was completed. Regional Nurse P did not give a reason to why the 2nd special order was followed.	N 196		

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N 277	Continued From page 2	N 277		
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 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 2 of 2 employees (who required continuing education) completed at least 15 hours of continuing education in 2024. This is a repeat deficiency. See Statements of Deficiency (SOD) 98QK11, dated 06/05/2023 and SOD Q6TG11, dated 08/12/20219. Findings include: On 02/04/2025, Surveyor reviewed employee files and identified the following: Caregiver G was hired 05/26/2015. Caregiver G's record included 5.25 hours of continuing education training in 2024. Caregiver Q was hired 12/16/2021. Caregiver Q's record included 8.25 hours of continuing education training in 2024.	N 277		

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N 277	Continued From page 3 On 02/04/2025 at 2:10 PM, Surveyor conducted an exit conference and shared findings with Interim Administrator N, Administrator O, and Regional Nurse P. The management team acknowledged they were aware when printing records of employee continuing education training, staff appeared to be short in hours. Surveyor requested additional documentation from the provider's electronic training platform that would include the duration of each class completed by Caregiver G and Caregiver Q. Regional Nurse P reported s/he would provide additional documentation by the end of day 02/05/2025. On 02/05/2025 at 9:51 PM, Regional Nurse P sent an email with Caregiver G's and Caregiver Q's online continuing education training completed for 2024. A review of the continuing education training did not change the above hours completed in 2024.	N 277		
{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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the community-based residential facility (CBRF) implemented and followed Resident 2's individual service plan (ISP) with regards to his/her diet as written. This is a repeat deficiency. See Statement of Deficiency (SOD) FV3E11, dated 10/03/2024.	{N 388}		

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{N 388}	Continued From page 4 Findings include: On 02/04/2025 at 12:00 PM, Surveyor interviewed Caregiver Q regarding resident diets. Surveyor showed Caregiver Q a resident roster and asked him/her to identify any residents with an altered diet. Caregiver Q identified Resident 2 as having a pureed diet. On 02/04/2025, from approximately 12:00 PM-12:25 PM, Surveyor observed residents in the memory care unit eating lunch. Surveyor observed 4 residents in the dining room and each resident had their own table, including Resident 2. Surveyor observed Resident 2 feeding him/herself a plate of pureed food. The pureed food included meat loaf, mashed potatoes, and seasoned corn. On 02/04/2025 at 1:00 PM, Surveyor interviewed Caregiver G regarding resident diets. Caregiver G reported Resident 2 had a pureed diet. Caregiver G reported Resident 2 used to be on a mechanical soft diet, but due to concerns with coughing, s/he was switched to pureed a few months ago. Caregiver G stated s/he did not know when it was switched, but it was a couple months ago. On 02/04/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 04/16/2024 with diagnosis including dementia and muscle weakness. Resident 2 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 2's most recent ISP dated 11/14/2024 documented: "[s/he] required physical assistance with all activities of daily living and Medications-I have my medication crushed with applesauce per physician order Dining/Eating/Drinking-I need staff to escort to	{N 388}		

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{N 388}	Continued From page 5 meal. I will be offered fluids 3 times a day with all meals and additional fluids offered during snacks/activities ....Specify custom interventions for dining/eating: Mechanical soft foods." Resident 1's physician order form dated 10/11/2024 documented: "General Diet Mechanical Soft." On 02/04/2025 at 1:55 PM, Surveyor interviewed Interim Administrator N regarding Resident 2's diet observed at lunch (pureed) vs their ISP (mechanical soft). Interim Administrator N confirmed Resident 2's diet order was for mechanical soft. Interim Administrator N reported the kitchen had the wrong diet order for Resident 2. On 02/04/2025 at 2:10 PM, Surveyor conducted an exit conference and shared findings with Interim Administrator N, Administrator O, and Regional Nurse P. The management team confirmed Resident 2 was supposed to have a mechanical soft diet served at lunch instead of the pureed texture s/he ate. Surveyor noted staff reported Resident 2's diet changed a couple months ago after episodes of coughing on mechanical soft. Interim Administrator N stated s/he would need to investigate further to determine how long Resident 2 was receiving the wrong diet order.	{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	N 389		

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N 389	Continued From page 6 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 observation, record review, and interview, the individual service plan (ISP) was not updated for 1 of 1 resident record reviewed when there was a change in resident needs and abilities. Resident 3's ISP was not updated to include the use of adaptive equipment to aid in transferring in and out of bed. This deficiency is being cited for the 4th time. See Statements of Deficiency (SOD) 98QK11, dated 06/05/2023, SOD Q6TG12, dated 02/24/2020, and SOD Q6TG11, dated 08/12/20219. According to the U.S. Food & Drug Administration's Hospital Bed Safety Workgroup, "...Strangling, suffocating, bodily injury, or death can occur when patients or parts of their bodies are caught between rails or between the bed rails and mattresses...Regardless of the purpose for which bed rails are being used or considered, a decision to utilize or remove those in current use should occur within the framework of an individual patient assessment...3. Use of bed rails should be based on patients' assessed medical needs and should be documented clearly...Bed rail effectiveness should be reviewed on a regular	N 389		

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N 389	Continued From page 7	N 389		

basis...The patient's chart should include a risk-benefit assessment that identifies why other care interventions are not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the patient. 4. Bed rail use for treatment of a medical symptom or condition should be accompanied by a care plan (treatment program) designed for that symptom or condition. The plan should present clear directions for further investigation of less restrictive care interventions. The documentation should describe the attempts to use less restrictive care interventions and, if indicated, their failure to meet patients' assessed needs...The care plan should: include educating the patient about possible bed rail danger to enable the patient to make an informed decision; and address options for reducing the risks of the rail use..." (Source: "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings" https://www.fda.gov/media/88765/download (retrieval date 02/05/2025)).

Findings include:

On 02/04/2025 at 11:58 AM, Surveyor observed Resident 3's bedroom and observed half rails attached to each side of Resident 3's hospital bed.

On 02/04/2025, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 09/30/2022 with a diagnosis of Alzheimer's disease. Resident 3's ISP dated 01/09/2025 identified him/her as a fall risk, required assistance with all actives of daily living, receiving hospice services and documented the following under Transfer: "I am dependent on staff for

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N 389	Continued From page 8 transfers on a regular basis. I am a pivot transfer to wheelchair with gait belt and on assist." The ISP did not address the use of half-length side rails. Resident 3's most recent annual assessment dated 10/02/2024 did not address the use of half-length side rails. On 02/04/2025 at 2:10 PM, Surveyor conducted an exit conference and shared findings with Interim Administrator N, Administrator O, and Regional Nurse P. The management team was unaware Resident 3 had half-length side rails on their bed but noted hospice must have installed them. Regional Nurse P acknowledged when side rails are used, the record should contain an assessment, and the intervention should be added to the resident's ISP. Regional Nurse P reported s/he would follow up with hospice and create an assessment in the provider's electronic health record.	N 389		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.	N 415		

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N 415	Continued From page 9 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure proper documentation within the Medication Administration Record (MAR) for 1 of 2 residents reviewed. Resident 3's sliding scale insulin units administered was not recorded from 12/01/2024-02/03/2025. Findings include: On 02/04/2025, Surveyor reviewed Resident 3's record and identified the following: Resident 3 was admitted to the provider on 09/30/2022 with diagnosis including Alzheimer's disease and type 2 diabetes. Resident 3 had an activated healthcare power of attorney. Resident 3's most recent individual service plan (ISP) dated 01/09/2025 documented staff administer Resident 3's medications. Resident 3's physician orders included the following: "Insulin ASPART 100 unit/ML (Novolog Flexpen) with instructions to inject subcutaneously before each meal per sliding scale: 125-175= 2 units, 176-225= 4 units, 226-275=6 units, 276-325=8 units, 326-375=10 units, 376-400= 12 units, 400 call doctor." Surveyor reviewed Resident 3's MARs from 12/01/2024-02/03/2025 and observed the following: Between 12/01/2024-02/03/2025, staff recorded 175 blood glucose levels that would have required sliding scale insulin. There was no documentation showing how many units of insulin Resident 3 was administered.	N 415		

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N 415	Continued From page 10 On 02/04/2025 at 2:10 PM, Surveyor conducted an exit conference and shared findings with Interim Administrator N, Administrator O, and Regional Nurse P. Surveyor noted concern in diabetic management in regard to missing documentation in Resident 3's record. Regional Nurse P reported after looking through the provider's electronic health record, staff did not record the number of sliding scale insulin units administered to Resident 3. The management team acknowledged Resident 3's number of sliding scale insulin units administered should have been recorded. Administrator O reported s/he added a question to Resident 3's MAR so staff will now record the number	N 415		