STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011775	A. BUILDING: _____ B. WING _____	R-C 12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	325 W COTTAGE GROVE ROAD COTTAGE GROVE, WI 53527

(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 From 12/16/2024 to 12/17/2024, Surveyors conducted 3 verification visits and a standard survey at Kindredhearts of Cottage Grove, a CBRF in Cottage Grove. Nineteen deficiencies were identified. Eleven deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) G0WL12, dated 03/24/2021, SOD G0WL13, dated 07/12/2021, SOD 8ITE11, dated 10/07/2021, SOD G0WL14, dated 02/23/2023, SOD G0WL15, dated 09/11/2023, SOD G0WL16, dated 02/23/2024, SOD G0WL17, dated 06/18/2024, Q19B11, dated 07/24/2024 and SOD K48W11, dated 09/04/2024. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 5	{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 observation, record review and interview, the provider did not ensure the CBRF and its operation complied with all laws governing the CBRF. This is a repeat deficiency. See Statement of Deficiency (SOD) 8ITE11, dated 10/07/2021, SOD G0WL15, dated 09/11/2024, SOD G0WL16, dated 02/23/2024 and SOD G0WL17, dated 06/18/2024.	{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
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{N 196}	Continued From page 1 Findings include: From 12/16/2024 to 12/17/2024, Surveyors completed 3 verification visits and a standard survey. As a result of the verification visits and standard survey, 19 deficiencies were identified, 11 of which were repeat deficiencies. The following concerns were noted: Environment: - Resident 10's room had a hole in the wall and lacked housekeeping services, which were the responsibility of staff. - Toxic substances were unsecured in 3 different locations throughout the facility. *Repeat deficiency - The provider did not have documentation indicating the furnace was serviced in the past 3 years. *Repeat deficiency - The provider did not have documentation indicating quarterly fire drills occurred in 2023 or 2024. *Repeat deficiency - The provider did not have documentation indicating semi-annual evacuation drills occurred in 2023 or 2024. - The provider did not have documentation indicating the sprinkler system had been inspected in the past year. *Repeat deficiency Employees: - Two of 3 caregivers reviewed were not screened for clinincally apparent disease, including tuberculosis, within 90 days before the start of employment. Resident Care:	{N 196}		

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{N 196}	Continued From page 2 - One of 2 residents reviewed did not have a communicable disease screen, including tuberculosis test, completed 90 days prior to or 7 days after admission. *Repeat deficiency - Four of 5 residents reviewed did not have a signed and dated admission agreement. *Repeat deficiency - Four of 5 residents reviewed did not have a signed statement documenting the appropriate decision maker had received an explanation of resident rights. *Repeat deficiency - Two of 5 residents reviewed did not receive their medications as prescribed. *Repeat deficiency - One of 6 residents reviewed did not have an assessment completed when s/he had a change in needs. *Repeat deficiency - Two of 6 residents reviewed did not have an individual service plan (ISP) that identified their needs. - Three of 3 residents reviewed did not have their ISP followed by the provider. - Two of 6 residents reviewed did not have their ISPs updated when there was a change in needs, abilities, or physical or mental condition. *Repeat deficiency - One of 1 residents reviewed that received a PRN psychotropic medication did not have the rationale for use and detailed description of behaviors which indicated the need for administration of the PRN medication documented in his/her ISP. - The provider did not complete daily audits of their schedule II medications. - Two of 2 residents reviewed did not have their medication errors reported to a licensed practitioner, supervising nurse or pharmacist. On 12/17/2024 at approximately 1:30 p.m., Surveyors reviewed environmental, employment and resident care concerns with Executive	{N 196}		

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{N 196}	Continued From page 3 Director N, who was affiliated with the management/consultant company hired by the licensee. Executive Director N stated the previous administrator, who was also affiliated with the management/consultant company hired by the licensee, had quit effective immediately the week prior. Executive Director N stated s/he was just helping Chief Operating Officer M that day by working with Surveyors because Chief Operating Officer M was out ill. On 12/17/2024 at approximately 12:15 p.m., Chief Operating Officer M emailed Surveyors stating s/he was at the facility and working on follow up documentation. Survyors then received follow up environmental documentation via email from Executive Director N. Chief Operating Officer M did not provide any additional documentation or comments regarding concerns reviewed with Executive Director N on 12/16/2024. Cross Reference: N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease N0302 DHS 83.28(4)(a) Resident Health Screening And Documentation N0310 DHS 83.29(2) Admission Agreement, Include Services And Charges N0343 DHS 83.32(2)(a) Explanation of Rights, Grievance Procedure N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medications N0381 DHS 83.35(a) Pre-Admission And Ongoing Assessments N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated	{N 196}		

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{N 196}	Continued From page 4 Annually Or On Changes N0408 DHS 83.37(1)(i)1. PRN Psychotropic Medication N0409 DHS 83.37(1)(j) Proof-Of-Use Record N0410 DHS 83.37(1)(k) Medication Error Or Adverse Reaction N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable N0499 DHS 83.45(3) Toxic Substances N0504 DHS 83.46(1)(c) Heating System Maintenance N0525 DHS 83.47(2)(d) Fire Drills N0526 DHS 83.47(2)(e) Other Evacuation Drills N0558 DHS 83.48(8)(b) Sprinkler System Installation And Maintenance	{N 196}		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 caregivers reviewed, were screened for clinically apparent	N 220		

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N 220	Continued From page 5	N 220		

communicable disease, including tuberculosis, within 90 days before the start of employment. Caregiver P and Caregiver Q were not screened for clinically apparent communicable disease, including tuberculosis, within 90 days before the start of employment.

Findings include:

On 12/16/2024, Surveyors conducted a review of 3 employees to verify compliance with all employee training requirements. Surveyors requested records of Caregiver P and Caregiver Q from Assistant Director O.

Caregiver P was hired on 08/21/2024. The provider did not have documentation indicating Caregiver P had a communicable disease screen within 90 days before 08/21/24. Records included a tuberculosis test, dated 08/26/2024, that was completed after the date of hire of 08/21/2024.

Caregiver Q was hired on 08/30/2024. The provider did not have documentation indicating Caregiver Q had a communicable disease screen within 90 days before 08/30/24. Records included a tuberculosis test, dated 09/25/2024, that was completed after the date of hire of 08/30/2024.

On 12/16/2024 at approximately 1:30 p.m., Surveyors interviewed Executive Director N. Surveyors stated the tuberculosis tests were completed after the date of hire for Caregiver P and Caregiver Q. Executive Director N acknowledged that records indicated that the communicable disease screen, including tuberculosis were completed after the date of hire.

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N 302	Continued From page 6	N 302		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 residents reviewed for a health screening upon admission were screened for communicable disease, including tuberculosis within 90 days before or 7 days after admission. Resident 10 was not screened for communicable disease, including tuberculosis, until greater than 6 months after his/her date of admission. This is a repeat deficiency. See Statement of Deficiency (SOD) G0WL14, dated 02/23/2023 and SOD G0WL15, dated 09/11/2023. Findings include: On 12/16/2024 at approximately 9:30 a.m., Surveyor reviewed Resident 10's record.	N 302		

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N 302	Continued From page 7 Resident 10 was admitted to the provider's facility on 03/09/2024. Resident 10's record included a communicable disease screen, dated 10/21/2024, and a tuberculosis test, dated 11/20/2024, both completed greater than 6 months after Resident 10's admission to the provider's facility. On 12/16/2024 at approximately 1:30 p.m., Surveyors reviewed concern with Executive Director N that Resident 10's communicable disease screen, including tuberculosis test, was not completed within 90 days prior to admission or 7 days after admission. Executive Director N acknowledged Surveyors' finding and stated the company s/he was affiliated with, who was a consulting/management company, must have found the error once they began working with the provider in the fall.	N 302		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in 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	N 310		

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N 310	Continued From page 8	N 310		

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 4 of 5 residents reviewed had a signed and dated admission agreement. Resident 5, Resident 6, Resident 10, and Resident 12 did not have an admission agreement signed and dated by themselves or their legal representative.

This is a repeat deficiency. See Statement of Deficiency (SOD) G0WL14, dated 02/23/2023, SOD G0WL15, dated 09/11/2023, SOD G0WL16, dated 02/23/2024 and SOD G0WI17, dated 06/18/2024.

Findings include:

On 12/16/2024 approximately 10:00 a.m., Surveyors reviewed resident records, which

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N 310	Continued From page 9 indicated the following: Example 1 - Resident 5: Resident 5 admitted to the provider's facility on 08/23/2012. Resident 5 was his/her own decision maker. Resident 5's record did not include a signed admission agreement. Example 2 - Resident 6: Resident 6 was admitted to the provider's facility on 12/11/2023. Resident 6 was his/her own decision maker. Resident 6's record did not include a signed admission agreement. Example 3 - Resident 10: Resident 10 was admitted to the provider's facility on 03/09/2024. Resident 10 was his/her own decision maker. Resident 10's record did not include a signed admission agreement. Example 4 - Resident 12: Resident 12 was admitted to the provider's facility on 07/03/2021. Resident 12 had an activated Health Care Power of Attorney. Resident 12's record did not include a signed admission agreement. On 12/16/2024 at approximately 1:30 p.m., Surveyors interviewed Executive Director N. Surveyors shared that Resident 5, Resident 6, Resident 10, and Resident 12's records did not include signed admission agreements. Executive Director N stated "[Management Company] is still working on getting admission agreements over to [facility staff] to get them completed."	N 310		

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N 343	Continued From page 10	N 343		
N 343	83.32(2)(a) Explanation of rights, grievance procedure. Explanation of resident rights, grievance procedure, and house rules. Before the admission agreement is signed by the resident or the resident ' s legal representative or at the time of admission, the CBRF shall provide a copy of and explain resident rights, the grievance procedure under s. HFS 83.33 and the house rules to the person being admitted, the person ' s legal representative, and family members of the person. The resident or the resident ' s legal representative shall be asked to sign a statement to acknowledge the receipt of an explanation of resident rights. The CBRF shall document the date and to whom the information was provided. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 5 resident records reviewed included a statement signed by themselves or their legal representatives acknowledging their receipt and explanation of resident rights or grievance procedures. Resident 5, Resident 6, Resident 10, and Resident 12 did not have a statement signed by themselves or their legal representatives that indicated they had received an explanation of resident rights or grievance procedures. This is a repeat deficiency. See Statement of Deficiency (SOD) G0WL14, dated 02/23/2023, G0WL15, dated 09/11/2023, G0WL16, dated 02/23/2024 and G0WL17, dated 06/18/2024. Findings include:	N 343		

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N 343	Continued From page 11 On 12/16/2024 at approximately 10:00 a.m., Surveyors requested documentation indicating residents and/or legal representatives had received an explanation of resident rights and grievance procedures for the following residents from Assistant Director O. Documentation was received that identified the following concerns: Example 1 - Resident 5: Resident 5 admitted to the provider's facility on 08/23/2012. Resident 5 was his/her own decision maker. Resident 5's record did not include a signed statement acknowledging his/her receipt and explanation of resident rights or grievance procedures. Example 2 - Resident 6: Resident 6 was admitted to the provider's facility on 12/11/2023. Resident 6 was his/her own decision maker. Resident 6's record did not include a signed statement acknowledging his/her receipt and explanation of resident rights or grievance procedures. Example 3 - Resident 10: Resident 10 was admitted to the provider's facility on 03/09/2024. Resident 10 was his/her own decision maker. Resident 10's record did not include a signed statement acknowledging his/her receipt and explanation of resident rights or grievance procedures. Example 4 - Resident 12: Resident 12 was admitted to the provider's facility on 07/03/2021. Resident 12 had an activated Health Care Power of Attorney. Resident 12's	N 343		

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N 343	Continued From page 12 record did not include a signed statement acknowledging his/her receipt and explanation of resident rights or grievance procedures. On 12/16/2024 at approximately 1:30 p.m., Surveyors interviewed Executive Director N. Surveyors shared that Resident 5, Resident 6, Resident 10, and Resident 12's records did not include signed statement acknowledging receipt and explanation of resident rights or grievance procedures. Executive Director N stated "[Management Company] is still working on getting admission agreements over to [facility staff] to get them completed." Executive Director N stated the admission agreement would contain the resident rights and grievance procedures with a signature page.	N 343		
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 5 residents reviewed received all medications in the dosage and at intervals prescribed by a practitioner. Resident 12 did not receive his/her Hydrocodone 10-325 as prescribed. Resident 10 did not receive his/her Diclofenac Sodium 1% gel as prescribed. This is a repeat deficiency. See Statement of	N 352		

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N 352	Continued From page 13	N 352		

Deficiency (SOD) G0WL14, dated 02/23/2023 and Q19B11, dated 07/24/2024.

Findings include:

On 12/16/2024 at approximately 9:30 a.m., Surveyor reviewed resident records and identified the following concerns:

Example 1 - Resident 12:

Resident 12 was admitted to the provider's facility on 07/03/2021 with diagnoses including vascular dementia, stroke and anoxic brain injury. Resident 12's physician orders included Hydrocodone (Start Date: 08/02/2023) - Take 1 tablet every 6 hours for lumbago with sciatica. Resident 12's Medication Administration Record (MAR), dated 12/01/2024 to 12/16/2024, documented Resident 12's Hydrocodone as "held" from 12/04/2024 at 2:00 p.m. through 12/10/2024 at 8:00 a.m. Resident 12's record did not include documentation of an order to hold the medication.

On 12/16/2024 at approximately 10:05 a.m., Surveyor interviewed Pharmacy R. Pharmacy R stated the pharmacy delivered a 28-day supply of Hydrocodone on 11/12/2024, indicating the supply should have lasted until 12/10/2024. Pharmacy R stated the pharmacy delivered an additional 28-day supply of Hydrocodone on 12/05/2024. Pharmacy R stated the pharmacy had no documentation of orders to hold Resident 12's Hydrocodone.
On 12/16/2024 at approximately 11:00 a.m., Surveyor reviewed the provider's proof-of-use record with Executive Director N, which indicated Resident 12 had 19 Hydrocodone tablets available on 12/04/2024 first shift and 0 tablets

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KINDREDHEARTS OF COTTAGE GROVE	325 W COTTAGE GROVE ROAD COTTAGE GROVE, WI 53527

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available on second shift. Surveyor and Executive Director N reviewed the provider's "destruction log" which did not document destruction of Resident 12's Hydrocodone tablets.

On 12/16/2024 at approximately 12:00 p.m., Surveyor interviewed Executive Director N and discussed concern that Resident 12 did not receive his/her Hydrocodone as prescribed from 12/04/2024 through 12/10/2024. Executive Director N confirmed that records indicated Resident 12 did not receive his/her medication as prescribed. Executive Director N stated the previous administrator, who no longer worked for the facility effective the week prior to Surveyor's visit, would have been the individual to document the medication as "held." Executive Director N stated s/he would assume that the previous director destructed Resident 12's Hydrocodone on 12/04/2024 with the anticipation of a new cycle fill, but was unable to provide documentation of destruction or explain why the Hydrocodone would have been destructed without confirmation that the facility had a new supply available.

On 12/16/2024 at approximately 12:55 p.m., Surveyor interviewed Resident 12. Resident 12 stated s/he recalled not receiving his/her Hydrocodone as prescribed earlier in the month. Resident 12 stated s/he required the medication due to left lower extremity pain and recalled having pain while the medications were missed.

Example 2 - Resident 10

Resident 10 was admitted to the provider's facility on 03/09/2024. Resident 10's physician orders included Diclofenac Sodium 1% gel (Start Date: 06/11/2024) - Apply 4 gm topically to hip 3 times daily. Resident 10's MAR, dated 12/01/2024 to

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N 352	Continued From page 15 12/31/2024, listed the Diclofenac Sodium 1% gel as on hold from 12/01/2024 to 12/31/2024. Surveyor reviewed Resident 10's record and was unable to locate documentation of a physician order to hold the medication. On 12/16/2024 at approximately 10:05 a.m., Surveyor interviewed Pharmacy R. Pharmacy R stated the pharmacy had no record of Resident 10's Diclofenac Sodium 1% gel being held or being requested by the provider's facility to be reordered. On 12/16/2024 at approximately 1:30 p.m., Surveyors reviewed concern with Executive Director N that Resident 10 did not receive his/her Diclofenac Sodium 1% gel from 12/01/2024 to 12/16/2024. Surveyors shared that Resident 10's MAR documented the medication as held; however, the facility's records and pharmacy records did not include a physician order for the medication to be held. Executive Director N stated the previous administrator who was no longer with the facility would have been the only person able to put the medication on "hold" and did not have an explanation as to why it was held with no order. Cross Reference: N0410 DHS 83.37(1)(k) Medication Error Or Adverse Reaction	N 352		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The	N 381		

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N 381	Continued From page 16 assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the needs, abilities and physical condition were assessed for 1 of 6 residents reviewed when there was a change in needs. Resident 12's physical condition and/or needs were not reassessed after sustaining falls. This is a repeat deficiency. See Statement of Deficiency (SOD) K48W11, dated 09/04/2024. Findings include: On 12/16/2024 at approximately 11:00 a.m., Surveyor reviewed Resident 12's record. Resident 12 was admitted to the provider's facility on 07/03/2021 with diagnoses including vascular dementia, stroke and anoxic brain injury. Resident 12's record included a "Fall Risk Assessment," dated 09/16/2024. The assessment indicated Resident 12 should use his/her cane when needed, use his/her pull cord for assistance when needed and that staff should complete "rounding" every 2 hours. Resident 12's individual service plan (ISP), dated 10/23/2024, indicated Resident 12 had no past history of falls and required no alternative safety measures. Resident 12's record, dated 09/01/2024 to 12/16/2024, included documentation of the following falls:	N 381		

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N 381	Continued From page 17 - 09/17/2024: Resident came out of his/her room at 5:00 a.m. stating s/he had fallen and got him/herself back up. Resident stated s/he lost his/her balance and fell on his/her butt. Resident was sent to ER for evaluation. No injuries documented. *The report did not include any further assessment/intervention to prevent further falls. - 09/19/2024: Resident came out of his/her room and stated s/he had gotten dizzy while using the bathroom. Resident reported that s/he had passed out and fell on the floor. Resident sat with staff in the living room for the remainder of the night. No injuries documented. *The report did not include any further assessment/intervention to prevent further falls. - 10/10/2024: Resident found on the floor in the common area. Resident reported that s/he was using the "in motion" machine and tried to stand up and lost his/her balance. No injuries documented. *The report did not include any further assessment/intervention to prevent further falls. - 11/08/2024: Resident was heard yelling. Staff found resident lying on the floor with feet near the bathroom door and head near his/her bed. Resident reported that s/he "blacked out" and fell. Resident was sent to ER. No injuries documented. *The report did not include any further assessment/intervention to prevent further falls. On 12/16/2024 at approximately 1:30 p.m., Surveyors interviewed Executive Director N. Surveyors shared that Resident 12's record included a "Fall Risk Assessment," dated 09/16/2024, but that s/he had sustained 4 falls since the assessment was completed and the record did not include an updated assessment.	N 381		

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N 381	Continued From page 18 Executive Director N reviewed Resident 12's record and confirmed s/he did not have documentation of an updated assessment related to falls since 09/16/2024.	N 381		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 6 residents reviewed had a individual service plan (ISP) developed that identified the resident's needs. Resident 10's ISP did not include his/her needs related to bathing, orientation/decision making, ambulation or transfers. Resident 6's ISP did not include his/her needs related to eating, diet, oral care, dressing, grooming, toileting, wandering/elopement, orientation/decision making skills, tobacco/alcohol use, bed check, ambulation, transfers, hearing, eyesight, skin care or door locks.	N 386		

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N 386	Continued From page 19 Findings include: On 12/16/2024 at approximately 9:30 a.m., Surveyor reviewed resident records and identified the following concerns: Example 1 - Resident 10: Resident 10 was admitted to the provider's facility on 03/09/2024 with diagnoses including morbid obesity, depression and anxiety. Resident 10's ISP, dated 10/23/2024, included the following: - Bathing: Shower/Bath 1x weekly. Bathes self. Needs assistance with bathing. Set-up and cueing needed for bathing. Full assist needed with bathing. Requires additional assistance due to resistance/refusal to bathing. Needs additional assistance due to bathing time of more than ½ hour. CAUTION BED BOUND RESIDENT. Resident requires daily bed bath due to current condition. Ensure usage of no-rinse shampoo and no rinse body wash. - Orientation/Decision Making Skills: Resident oriented to time and place. Requires no staff assistance to redirect and reorient. Resident occasionally disoriented to time and place which requires staff assistance to redirect and/or reorient. Resident frequently disoriented to time and place (more than once daily) which requires additional staff assistance to redirect and reorient. Resident is able to comprehend and retain a request. Resident only able to retain portions of a request. Resident not able to retain any requests for any length of time. Resident can recognize and make decision on their own and is able to communicate needs for care and can identify safety hazards. Resident does not always recognize when to make decisions but follows	N 386		

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directions. Resident needs regular assistance regarding safety hazards and decision-making skills and requires one step directions.
- Physical Disabilities - Ambulation: Impaired physical mobility. Resident ambulates without assistance or uses cane, walker, or wheelchair without staff assistance or reminders. Resident ambulates without assistance or uses cane, walker or wheelchair without staff assistance but needs consistent reminders to use adaptive equipment such as: Resident ambulates with instruction/cueing assistance from staff to use cane, walker, or with 1 person hands on assistance with gait belt for use of cane or walker. Resident ambulates with 2 person hands on assistance with gait belt and walk behind wheelchair for use of cane or walker.
- Physical Disabilities-Transferring: Impaired physical mobility. Resident transfers independently. Resident needs 1 person to stand by (with no hands on) when transferring. Resident requires assistance from 1 staff with gait belt for transfers. Resident requires sit/stand lift for all transfers. Resident requires hoyer lift (total assistance) for all transfers.

Example 2 - Resident 6:

Resident 6 was admitted to the provider's facility on 12/11/2023 with diagnoses including dementia and depression. Resident 6's ISP, dated 10/23/2024, included the following concerns:

- Eating/Nutrition: Appetite is good/fair/poor. 1) Resident is independent with eating. Resident is not currently a coking risk. Resident is able to eat independently in both common area and bedroom as s/he wishes and does not require any additional supervision. Resident receives 3 meals per day and snacks. ENTER INFORMATION ON

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N 386	Continued From page 21 SUPPLMENET IF NEEDED AND HOW OFTEN. (I.e., Resident requires Ensure, protein shakes, etc.) 2) Resident needs additional monitoring during mealtime due to resident being an increased choking risk. Resident requires ENTER WHAT IS NEEDED (I.e., mechanical soft foods, meats to be chopped, pureed food, nectar-thickened liquids, honey thickened liquids). Resident receives 3 meals per day and snacks. Resident is to be encouraged to eat in dining room. If resident wishes to eat a meal in his/her room, s/he would require staff to be present during entire meal. Document if increased assistance is needed. ENTER INFORMATION ON SUPPLMENENT IF NEEDED AND HOW OFTEN (I.e., Resident requires Ensure, protein shakes, etc.) CAUTION BED BOUND RESIDENT: Due to resident's condition, requires eating and assistance in room for eating, elevate bed or place pillows behind resident to sit in upright position. If resident refuses meal, set task to offer snack in 1 hour and continue until a meal is eaten. - Oral Care: Resident has own teeth/dentures (upper/lower), partials (upper/lower). Resident can perform all oral care independently. Resident requires cueing or reminders for oral care. Resident requires set-up and some assistance for oral care. Resident requires total assistance with set-up/finding supplies/completion of task. CAUTION BED BOUND RESIDENT: Resident requires mouth swabs/Vaseline to lips to keep mouth from drying out. - Dressing/Undressing: Dresses/undresses self. Needs only assistance with TED hose. Needs reminders or cueing for dressing/undressing. Needs assistance choosing clothing and some assistance with dressing/undressing. Requires total assistance w/dressing. Needs assistance throughout day to redress due to	N 386		

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N 386	Continued From page 22 disrobing/incontinence. CAUTION: BED BOUND RESIDENT. Resident requires dressing/undressing in bed. Use pants with Velcro sides/hospital type gown with opening to back that is easily removed. - Grooming: Resident can perform all grooming tasks (wash hands/face, sponge bath, comb hair, shave, use deodorant) independently. Assist as needed. Resident requires cueing or reminders to complete some or all tasks. Resident requires set-up and some assistance to complete all or some tasks. Resident requires total assistance with set-up, finding supplies, completion of tasks. - Toileting: Resident is continent/incontinent of bowel/bladder. Resident requires assistance/is independent in toileting needs. Resident is able to get on/off toilet and complete peri care without assistance. Resident requires prompting, reminders/cueing but can toilet independently. Resident remains continent but requires assistance with toileting/peri care. Resident occasionally needs assistance with the use of incontinence products or related hygiene needs. Resident requires daily or more often assistance with the use of incontinence products or related hygiene needs. Resident requires staff assistance to perform catheter or ostomy care. Resident requires staff assistance to empty or clean urinal/bedside commode. Resident requires assistance with additional monitoring due to frequent constipation/diarrhea. Resident requires assistance with toileting schedule. Resident requires monitoring/measuring of output or bowel program. Resident is incontinent/continent of bowel/bladder. Resident uses depends/pads for incontinence. CAUTION BED BOUND RESIDENT: Resident requires 2 hour toileting to bathroom/commode/via urinal/via bedpan. Ensure placement of bed pad or bed at all times. Resident requires assistance with peri-care.	N 386		

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N 386	Continued From page 23 - Wandering/Elopement: Resident does not wander. Resident exhibits occasional wandering/packing [sic] within residence, needs minimal redirection. Resident exhibits frequent wandering within residence, needs frequent reminders/redirection. Resident wanders/trespasses into other rooms but is easily redirected. Resident wanders outside of residence; responds to minimal redirection. Resident wanders outside of residence; resistive to redirection. If elopement attempt made, 15 minute checks are begun for 24 hour period. - Orientation/Decision Making Skills: Resident is oriented to time and place. Requires no staff assistance to redirect and reorient. Resident occasionally disoriented to time and place which requires staff assistance to redirect and/or reorient. Resident frequently disoriented to time and place (6 or more times a week) which requires staff assistance to redirect and reorient. Resident frequently disoriented to time and place (more than once daily) which requires additional staff assistance to redirect and reorient. Resident is able to comprehend and retain a request. Resident only able to retain portions of a request. Resident not able to retain any requests for any length of time. Resident can recognize and make decisions on their own and is able to communicate needs for care and can identify safety hazards. Resident does not always recognize when to make decisions but follows directions. Resident needs regular assistance regarding safety hazards and decision-making skills and requires one step directions. - Tobacco/Alcohol Use: Resident is a non-smoker/non-drinker or drinks/smokes independently. Resident requires reminders to smoke in designated areas or requires monitoring of alcohol intake. Resident requires supervision with alcohol/tobacco or staff are responsible for	N 386		

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storage and distribution of product. Resident requires cigarette to be lit or needs alcohol distributed sparingly due to safety/abuse issues. Resident requires staff presence while smoking/drinking due to safety/abuse issues; staff manage all cigarette/alcohol use.
- Bed Check: Resident will be checked on a minimum of two times nightly or more often as needed. Resident will be checked on _____ night due to : [no entry].
- Physical Disabilities - Ambulation: Impaired physical mobility. Resident ambulates without assistance or uses cane, walker, or wheelchair without staff assistance or remainders. Resident ambulates without assistance or uses cane, walker or wheelchair without staff assistance but needs consistent reminders to use adaptive equipment such as: Resident ambulates with instruction/cueing assistance from staff to use cane, walker or wheelchair. Resident ambulates with standby (walk beside with no hands on) assistance while using cane/walker. Resident ambulates with 1 person hands on assistance with gait belt for use of cane or walker. Resident ambulates with 2 person hands on assistance with gait belt and walk behind wheelchair for use of cane or walker.
- Physical Disabilities - Transferring: Impaired physical mobility. Resident transfers independently. Resident needs 1 person to stand by (with no hands on) when transferring. Resident requires assistance from 1 staff with gait belt for transfers. Resident requires sit/stand lift for all transfers. Resident requires hoyer lift (total assistance) for all transfers.
- Hearing: Hearing is good, fair, poor. Resident hears well and understands others without staff assistance or use of hearing devices. Resident is hearing impaired, uses hearing devices in left/right ear but does not require assistance.

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N 386	Continued From page 25 Resident is hearing impaired, uses hearing devices in left/right ear but requires staff assistance/time to communicate by: [no entry]. - Eye Sight: Eye sight is good/fair/poor. Requires use of visual aids such as: resident sees adequately without glasses or staff assistance. Resident sees adequately with the use of glasses/contacts and does not require staff assistance. Resident is partially/totally blind and requires minimal staff assistance. Resident is partially/totally blind and requires daily staff assistance. Resident requires frequently reminders to wear glasses. Resident requires frequent assistance to find glasses and eyewear care of glasses. - Skin Care: 1) Resident's skin is in good condition with no open wounds, able to monitor skin and apply lotions independently. 2) Resident requires skin assessments more often than once weekly with showers due to increased potential for breakdown. 3) Resident has open area(s) that require treatment as follows: for the open area(s) - list where open area(s) are: (May accompany separate care plan item of daily skin monitoring) 4) CAUTION BED BOUND RESIDENT: Perform daily/twice daily/per shift skin checks. Pay close attention to the skin on the back of the ears, buttocks, heels, elbows and back. Look for reddened areas. If noticed, call [director] immediately. - Lock on Residents Door: Resident has a key to lock his or her door. Resident chooses to keep key to his or her door in designated locked area in [director] office. Resident's door lock Is disabled due to (describe reason door lock has been disabled). On 12/16/2024 at approximately 1:30 p.m., Surveyors reviewed concern with Executive Director N that Resident 10 and Resident 6's	N 386		

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(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 386	Continued From page 26 record did not identify their needs in several areas. As Surveyor reviewed the ISPs with Executive Director N, Executive Director N responded, "Oh" and explained that whoever completed the ISPs did not "select" the level of need, so nothing was specified.	N 386		
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 the individualized service plan (ISP) of 3 of 3 residents reviewed was followed. Resident 6, Resident 10, and Resident 12 did not have their vitals monitored weekly as indicated in their ISPs. Findings include: On 12/16/2024 approximately 10:00 a.m., Surveyors reviewed resident ISP records, which indicated the following: Example 1- Resident 6: Resident 6 was admitted to the provider's facility on 12/11/2023. Resident 6's ISP, dated 10/23/2024, stated "Vitals": "Directions: ...Take vitals and record in daily tasks. NOTE: CONTACT [Resident Director] ON CALL for any of the following vitals: Pulse below 50 or above 100; Systolic [Blood Pressure] lower than 90 or higher than 160; diastolic BP (bottom number) lower than 50 or higher than 110; weight loss or gain of more than 5 pounds since last month at this time;	N 388		

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N 388	Continued From page 27	N 388		

temp over 100 ... Current Status: Vitals taken and recorded weekly." Vitals were listed as including blood pressure, pulse, temperature, respirations, and weight.

Resident 6's vitals history from 09/01/2024 through 12/16/2024 indicated the following:

-Blood Pressure documented 7 out of 15 entries.
-Pulse documented 7 out of 15 entries.
-Temperature documented 7 times out of 15 entries.
-Respirations documented 7 times out of 15 entries.
-Weight documented 4 out of 15 entries.

Example 2 - Resident 10:

Resident 10 was admitted to the provider's facility on 03/09/2024. Resident 10's ISP, dated 10/23/2024, stated "Vitals": "Directions: ...Take vitals and record in daily tasks. NOTE: CONTACT [Resident Director] ON CALL for any of the following vitals: Pulse below 50 or above 100; Systolic [Blood Pressure] lower than 90 or higher than 160; diastolic BP (bottom number) lower than 50 or higher than 110; weight loss or gain of more than 5 pounds since last month at this time; temp over 100 ... Current Status: Vitals taken and recorded weekly." Vitals were listed as including blood pressure, pulse, temperature, respirations, and weight.

Resident 10's vitals history from 09/01/2024 through 12/16/2024 indicated the following:

-Blood Pressure documented 8 out of 15 entries.
-Pulse documented 8 out of 15 entries.
-Temperature documented 8 times out of 15 entries.

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N 388	Continued From page 28 -Respirations documented 8 times out of 15 entries. -Weight documented 3 out of 15 entries. Example 3 - Resident 12 Resident 12 was admitted to the provider's facility on 07/03/2021. Resident 12's ISP, dated 10/23/2024, stated "Vitals": "Directions: ...Take vitals and record in daily tasks. NOTE: CONTACT [Resident Director] ON CALL for any of the following vitals: Pulse below 50 or above 100; Systolic [Blood Pressure] lower than 90 or higher than 160; diastolic BP (bottom number) lower than 50 or higher than 110; weight loss or gain of more than 5 pounds since last month at this time; temp over 100 ... Current Status: Vitals taken and recorded weekly." Vitals were listed as including blood pressure, pulse, temperature, respirations, and weight. Resident 12's vitals history from 09/01/2024 through 12/16/2024 indicated the following: -Blood Pressure documented 11 out of 15 entries. -Pulse documented 11 out of 15 entries. - Respirations documented 10 out of 15 entries. -Weight documented 5 out of 15 entries. On 12/16/2024 at approximately 1:30 p.m., Surveyors reviewed concern with Executive Director N that Resident 6, Resident 10, and Resident 12's vitals were not taken weekly as indicated in the ISPs. Executive Director N reviewed the vitals record and stated that taking vitals weekly was probably an error with the electronic charting program because it auto populates to the weekly setting.	N 388		

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{N 389}	Continued From page 29	{N 389}		
{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 2 of 6 individual service plans (ISP) reviewed were updated when there was a change in the resident's needs, abilities or physical or mental condition. Resident 6's ISP was not updated to include his/her alcohol use. Resident 8's ISP was not updated to include his/her aggressive behaviors. This is a repeat deficiency. See Statement of Deficiency (SOD) G0WL14, dated 02/23/2023, G0WL15, dated 09/11/2023 and G0WL16, dated 02/23/2024 and G0WL17, dated 06/18/2024. Findings include: On 12/16/2024 at approximately 9:30 a.m., Surveyor reviewed resident records and identified the following concerns:	{N 389}		

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{N 389}	Continued From page 30 Example 1 - Resident 6: Resident 6 was admitted to the provider's facility with diagnoses including depression and dementia. Resident 6's ISP, dated 10/23/2024, did not specify whether s/he drank alcohol. Resident 6's progress notes, dated 09/01/2024 to 12/16/2024, including the following documentation regarding alcohol use: - 09/16/2024: Writer noticed resident was drunk and slurring his/her words. Resident was being belligerent with staff, telling staff not to talk to him/her, using profanity as well. - 09/20/2024: Resident was under the influence of alcohol on Friday night. Writer could smell it coming from resident's breath. Resident was screaming and yelling at staff for no reason. Resident was threatening to move out and move to a new home. Resident stated s/he hated this place and will be packing his/her belongings and moving out. - 10/01/2024: Message was left with physician about medication concerns with resident taking CBD, drinking alcohol and being on Morphine 4x daily. Writer awaiting response from the doctors office. - 10/04/2024: Follow up regarding 10/01/2024 observation. Writer made contact with the doctor and they will not be increasing the Morphine to 4x daily. They will be leaving it at 3x daily as of right now. On 12/16/2024 at approximately 12:45 p.m., Surveyor interviewed Caregiver P. Caregiver P confirmed Resident 6 had a history of drinking. Caregiver P stated Resident 6 drinks every 1-2 weeks and his/her gait became unsteady when drinking.	{N 389}		

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{N 389}	Continued From page 31 Resident 6's ISP was not updated to include his/her alcohol use. Example 2 - Resident 8 Resident 8 was admitted to the provider's facility on 03/08/2024. Resident 8's ISP, not dated, did not include documentation of any behaviors. Resident 8's progress notes, dated 10/28/2024 to 11/26/2024, identified the following behavioral concerns: - 10/28/2024: Resident was disrespectful and rude. Resident threw staff members belongings and laptop on the floor. Refused to return staff member's notebook. Resident made false accusations toward staff. - 11/07/2024: Resident was being racist and rude to staff. - 11/08/2024: More harassment to staff. Called staff [expletive]. - 11/11/2024: Resident refused to go to his/her room to use his/her urinal and was using it in the living room, making other residents uncomfortable. When redirected, resident dumped the urinal contents on the floor and told staff to "Shut the [expletive] up and clean it up." - 11/11/2024: Resident was yelling at another resident regarding the tv. - 11/13/2024: Resident had the tv remote and had been sticking it under him/her so nobody else can use it. Resident called staff a "fat [expletive] [expletive]" and that staff were not allowed to tell resident what s/he can and cannot do. - 11/14/2024: Became upset in the living room. Began calling staff "worthless pieces of [expletive]" and tried throwing objects at staff. - 11/26/2024: Law enforcement was called due to resident assaulting a staff member.	{N 389}		

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{N 389}	Continued From page 32 On 12/16/2024 at approximately 1:30 p.m., Surveyors reviewed concern with Executive Director N that Resident 8's progress notes identified a history of behaviors, but his/her ISP did not include documentation of behaviors or interventions related to behaviors. Executive Director N agreed with Surveyors' concern and stated s/he wasn't familiar with the resident since a different administrator was responsible for the facility up until a week prior to Surveyors' visit. Surveyor reviewed his/her record and stated Resident 8 had been hospitalized on 11/26/2024 for wound care but s/he did not have further details regarding resident status.	{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, 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.	N 408		

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N 408	Continued From page 33 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 residents reviewed that received a PRN psychotropic medication had the rationale for use and detailed description of behaviors, which indicated the need for administration of the PRN medication, documented in his/her individual service plan (ISP). Resident 6's ISP did not include the use of his/her Hydroxyzine Hcl PRN. Findings include: On 12/16/2024 at approximately 9:30 a.m., Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider's facility on 12/11/2023. Resident 6's physician orders included Hydroxyzine Hcl 25 mg (Start Date: 02/26/2024) 1 tablet by mouth 4 times daily as needed for anxiety. Resident 6's ISP, dated 10/23/2024, did not include the use of his/her Hydroxyzine Hcl PRN. On 12/16/2024 at approximately 1:30 p.m., Surveyor reviewed concern with Executive Director N that Resident 6's use of Hydroxyzine Hcl PRN was not included in his/her ISP. Executive Director N made note of Surveyor's concern and stated the ISPs needed updating. Executive Director N explained the previous administrator was no longer with the facility effective last week, so the residents were "new" to Executive Director N.	N 408		
N 409	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject	N 409		

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N 409	Continued From page 34 to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure proof-of-use records were audited daily. Resident 12's Hydrocodone was not audited daily and the provider did not have documentation to explain discrepancies in tablet count when identified. Findings include: On 12/16/2024 at approximately 10:15 a.m., Surveyor reviewed the provider's proof-of-use record with Executive Director N for Resident 12's Hydrocodone. Surveyor requested documentation of daily audits from 12/01/2024 to 12/16/2024. Executive Director N was unable to provide documentation of a daily audit on the following dates: 12/01/2024 (Document stated "Not counted") and 12/02/2024. As Surveyor reviewed the daily audits, Surveyor noted that Resident 12's daily count of Hydrocodone on 12/04/2024 first shift was 19 and the daily count on 12/04/2024 second shift was 0. The provider's destruction log included no documentation of destruction for Resident 12's Hydrocodone, no investigation as to what happened to the Hydrocodone and Resident 12's record indicated s/he did not receive his/her	N 409		

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N 409	Continued From page 35 Hydrocodone as prescribed from 12/04/2024 at 2:00 p.m. through 12/10/2024 at 8:00 a.m. On 12/16/2024 at approximately 10:30 a.m., Surveyor reviewed the provider's medication cart with Caregiver P. Surveyor and Caregiver P observed that Resident 12 had 86 tablets of Hydrocodne available. Surveyor then reviewed the "Proof of Use" for 12/16/2024 first shift that indicated 89 tablets were available. Since that count, Resident 12 had been administered his/her 8:00 a.m. dose, which would have made the count 88. On 12/16/2024 at approximately 1:30 p.m., Surveyors reviewed concern with Executive Director N that Resident 12's Hydrocodone was not audited daily, that there was no documentation regarding his/her counts going from 19 to 0 on 12/04/2024 and that there was a discrepancy with the current count. Executive Director N confirmed there were dates when a daily audit did not occur and that s/he could only assume the previous administrator destructed Resident 12's Hydrocodone tablets the day his/her count went from 19 to 0. Executive Director N was unable to explain the discrepancy in Resident 12's current Hydrocodone count.	N 409		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner,	N 410		

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supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure an error in medication administration was reported to a licensed practitioner, supervising nurse or pharmacist immediately for 2 of 2 residents who had medication errors. The provider did not immediately notify a licensed practitioner, supervising nurse or pharmacist when Resident 12 did not receive his/her Hydrocodone as prescribed, and Resident 10 did not receive his/her Diclofenac Sodium gel as prescribed.

This is a repeat deficiency. See Statement of Deficiency (SOD) Q19B11, dated 07/24/2024.

Findings include:

On 12/16/2024 at approximately 9:30 a.m., Surveyor reviewed resident records and identified the following concerns:

Example 1 - Resident 12:

Resident 12 was admitted to the provider's facility on 07/03/2021 with diagnoses including vascular dementia, stroke and anoxic brain injury. Resident 12's physician orders included Hydrocodone (Start Date: 08/02/2023) - Take 1 tablet every 6 hours for lumbago with sciatica.

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Resident 12's Medication Administration Record (MAR), dated 12/01/2024 to 12/16/2024, documented Resident 12's Hydrocodone as "held" from 12/04/2024 at 2:00 p.m. through 12/10/2024 at 8:00 a.m. Resident 12's record did not include documentation of an order to hold the medication. Resident 12's record did not include documentation of communication with a licensed practitioner, supervising nurse or pharmacist regarding Resident 12's missed doses of Hydrocodone.

On 12/16/2024 at approximately 10:05 a.m., Surveyor interviewed Pharmacy R. Pharmacy R stated the pharmacy had no documentation of orders to hold Resident 12's Hydrocodone.

On 12/16/2024 at approximately 12:00 p.m., Surveyor interviewed Executive Director N and discussed concern that Resident 12 did not receive his/her Hydrocodone as prescribed from 12/04/2024 through 12/10/2024.

On 12/16/2024 at approximately 12:55 p.m., Surveyor interviewed Resident 12. Resident 12 stated s/he recalled not receiving his/her Hydrocodone as prescribed earlier in the month. Resident 12 stated s/he required the medication due to left lower extremity pain and recalled having pain while the medications were missed.

On 12/16/2024 at approximately 1:30 p.m., Surveyors reviewed concern with Executive Director N that Resident 12 missed doses of Hydrocodone, but the record did not indicate a licensed practitioner, supervising nurse or pharmacist was notified of the missed doses. Executive Director N stated the previous administrator would have known Resident 12 was not receiving his/her Hydrocodone because s/he

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would have been the individual to place the medication on "hold" in the electronic charting system. Executive Director N stated if communication had occurred with a licensed practitioner, supervising nurse or pharmacist, the communication should have been documented in Resident 12's progress notes.

Example 2 - Resident 10

Resident 10 was admitted to the provider's facility on 03/09/2024. Resident 10's physician orders included Diclofenac Sodium 1% gel (Start Date: 06/11/2024) - Apply 4 gm topically to hip 3 times daily. Resident 10's MAR, dated 12/01/2024 to 12/16/2024, listed the Diclofenac Sodium 1% gel as on hold from 12/01/2024 to 12/31/2024. Surveyor reviewed Resident 10's record and was unable to locate documentation of a physician order to hold the medication.

On 12/16/2024 at approximately 10:05 a.m., Surveyor interviewed Pharmacy R. Pharmacy R stated the pharmacy had no record of Resident 10's Diclofenac Sodium 1% gel being held or being requested by the provider's facility to be reordered.

On 12/16/2024 at approximately 1:30 p.m., Surveyors reviewed concern with Executive Director N that Resident 10 did not receive his/her Diclofenac Sodium 1% gel from 12/01/2024 to 12/16/2024, but the record did not indicate a licensed practitioner, supervising nurse or pharmacist was notified of the missed doses. Executive Director N stated the previous administrator would have known Resident 10 was not receiving his/her Diclofenac Sodium 1% gel because s/he would have been the individual to place the medication on "hold" in the electronic

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDREDHEARTS OF COTTAGE GROVE	325 W COTTAGE GROVE ROAD COTTAGE GROVE, WI 53527

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N 410	Continued From page 39 charting system. Executive Director N stated if communication had occurred with a licensed practitioner, supervising nurse or pharmacist, the communication should have been documented in Resident 10's progress notes. Cross Reference: N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medications	N 410		
N 481	83.43(1) Environment safe, clean, and comfortable 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 safe, clean, comfortable and homelike environment was provided for Resident 10. Findings include: On 12/16/2024 at approximately 9:40 a.m., Surveyor observed Resident 10's room and interviewed Resident 10. The following concerns were identified: - Resident 10 had 2 laundry baskets overflowing with clothing sitting next to his/her recliner. Resident 10 reported the laundry was clean; however, staff did not assist him/her with putting his/her laundry away so s/he just pulled laundry from the baskets as s/he needed it.	N 481		

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N 481	Continued From page 40 - Resident 10's toilet had feces smeared throughout the surface of the rim and inside the bowel. Resident 10 stated staff were responsible for cleaning his/her bathroom. - Resident 10 had a hole, greater than 6 inches in width, on the wall, near his/her window. Resident 10 stated the hole had been there since the summer and s/he wasn't sure why the provider had yet to fix it. On 12/16/2024 at approximately 10:00 a.m. Surveyor reviewed Resident 10's individual service plan (ISP), dated 10/23/2024, which indicated the provider's staff was responsible for Resident 10's housekeeping and laundry tasks. On 12/16/2024 at approximately 1:30 p.m., Surveyor reviewed concerns regarding Resident 10's room with Executive Director N. Surveyor showed Executive Director N pictures of the findings. Executive Director N replied, "Oh my God," as s/he wrote down Surveyor's concerns.	N 481		
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 all toxic substances were stored in a secured area. The provider had toxic substances accessible to residents in 3 areas of the facility. This is a repeat deficiency. See Statement of	N 499		

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N 499	Continued From page 41 Deficiency (SOD) G0WL14, dated 02/23/2023, SOD G0WL15, dated 09/11/2023 and SOD G0WL16, dated 02/23/2024. Findings include: The provider is licensed to serve up to 15 residents with diagnoses including advanced age and irreversible dementia/Alzheimer's. On 12/16/2024 at approximately 9:30 a.m., Surveyor toured the provider's facility and observed the following concerns: Example 1 - Cleaning Closet The provider's cleaning closet was unlocked and accessible. The closet contained the following: - LSR Delimer (Label: Danger Corrosive. Causes severe burns) - R-T-U Quaternary FCS Sanitizer (Label: Keep out of reach of children) - KILZ Odorless (Label: Keep out of reach of children) - Drain Opener (Label: Poison. Burns Severely On Contact) - Old English Furniture Polish (Label: Keep out of reach of children. Caution: Contents under pressure) - Lemon Furniture Polish (Label: Harmful or fatal if swallowed. Extremely flammable.) - WD-40 (Label: Danger Flammable. Contents under pressure. Harmful or fatal if swallowed.) Example 2 - Laundry Room The provider's laundry room was unlocked and accessible. The room contained the following:	N 499		

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N 499	Continued From page 42 - XTra laundry detergent (Label: Caution. Eye irritant. Harmful if swallowed was on the counter.) - Fabuloso (Label: Keep out of reach of children) Example 3 - Resident 10's Room Resident 10's bathroom contained Clorox Disinfectant Cleaner with Bleach (Label: Keep out of reach of children). As Surveyor observed the cleaning substance in Resident 10's bathroom, Surveyor asked Resident 10 if s/he cleaned his/her own bathroom. Resident 10 reported staff were responsible for cleaning his/her bathroom. On 12/16/2024 at approximately 1:30 p.m., Surveyors reviewed concern with Executive Director N that toxic substances were accessible in several locations throughout the facility. Executive Director N wrote down Surveyors' concern and had no comment regarding the concern.	N 499		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2.	N 504		

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N 504	Continued From page 43 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the facility's furnace was serviced at least once every 3 years and that documentation was available to the department. This is a repeat deficiency. See Statement of Deficiency (SOD) G0WL12, dated 03/24/2021. Findings include: On 12/16/2024 at approximately 9:30 a.m., Surveyors reviewed the provider's environmental records. The records did not include a furnace inspection completed in the past 3 years. On 12/16/2024 at approximately 1:30 p.m., Surveyors asked Executive Director N if the provider had a furnace inspection completed in the past 3 years. Executive Director N stated that "[Chief Operation Officer M] and [Executive Director N] had been unable to find it."	N 504		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping	N 525		

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N 525	Continued From page 44 hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct quarterly fire drills for 2023 and 2024. There were no documented fire drills in 2023. There was one documented fire drill for 2024, which did not include the time the drill occurred. This is a repeat deficiency. See SOD GOWL14, dated 02/23/2023. Findings include: On 12/16/2024 at approximately 9:00 a.m., Surveyors reviewed the facility's environmental records. There were no documented fire drills in 2023 and one documented fire drill for 2024, dated 09/12/024, that did not include time the drill occurred. Surveyors asked Assistant Director O if there were any more documented fire drills for 2023 and 2024. On 12/16/2024 at approximately 1:30 p.m., Surveyors discussed the above concern with Executive Director N. Executive Director N acknowledged they were unable to provide documentation of 2023 and 2024 fire drills. Executive Director N explained that s/he knew the facility had completed a couple drills because s/he helped set up the environmental binder. Executive Director N was given until 12/17/2024 at 2:00 p.m. to provide follow up documentation.	N 525		

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N 525	Continued From page 45 Surveyors did not receive any additional documentation of fire drills.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that semi-annual evacuation drills for 2023 and 2024 were completed. Findings include: On 12/16/2024 at approximately 9:00 a.m., Surveyors reviewed the facility's environmental records for semi-annual evacuation drills. Surveyors found no documented evacuation drills for 2023 and 2024. Surveyors asked Assistant Director O if there was any evidence of documented semi-annual evacuation drills for 2023 and 2024. Assistant Director O stated that all drills were in the binder. On 12/16/2024 at approximately 1:30 p.m., Surveyors discussed the above concern with Executive Director N. Executive Director N acknowledged that there were no documented semi-annual evacuation drills for 2023 and 2024. Executive Director N was given until 12/17/2024 at 2:00 p.m. to provide follow up documentation. Surveyors did not receive any additional documentation of evacuation drills.	N 526		

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N 558	Continued From page 46	N 558		
N 558	83.48(8)(b) Sprinkler system installation and maintenance Installation and maintenance. 1. All sprinkler systems shall be installed by a state licensed sprinkler contractor. All sprinkler systems shall be maintained, inspected and tested at least annually or at intervals determined by the requirements in NFPA 25. 2. In facilities with sprinklers, sprinkler heads shall be placed at the top of each linen or trash chute and in the rooms where the chutes terminates. 3. The sprinkler system flow alarm shall be connected to the CBRF ' s fire alarm system. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the sprinkler system was inspected and tested at least annually. The provider was unable to provide evidence of any sprinkler inspection in the past year. This is a repeat deficiency. See Statement of Deficiency (SOD) G0WL14, dated 02/23/2023, and G0WL15, dated 09/11/2023. Findings include: On 12/16/2024 at approximately 8:30 a.m., Surveyors requested the facility's environmental records, including the most recent sprinkler system inspection, from Assistant Manager O. On 12/16/2024 at approximately 9:00 a.m., Surveyors reviewed the facility's environmental records. There was no documentation of a sprinkler system inspection. On 12/16/2024 at 1:30 p.m., Surveyors discussed concern that records did not include	N 558		

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N 558	Continued From page 47 documentation of a sprinkler system inspection. Executive Director N stated s/he was unable to locate documentation of a sprinkler system inspection. Executive Director N explained that s/he knew the facility changed inspection companies but did not have the most recent records of the annual inspection. Executive Director N was given until 12/17/2024 at 2:00 p.m. to provide follow up documentation. Surveyors did not receive documentation of a sprinkler system inspection	N 558		