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OUR HOUSE EAU CLAIRE MEMORY CARE	733 W HAMILTON AVE EAU CLAIRE, WI 54701

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N 000	Initial Comments On 02/13/2024, Surveyors conducted a standard survey and 3 complaint investigations at Our House Eau Claire Memory Care. Data collection continued through 02/21/2024. One of 3 complaints was substantiated. Four deficiencies were identified. Census: 14	N 000		
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 2 of 4 residents sampled (Resident 3 and Resident 4) were screened for communicable disease, including tuberculosis, within 7 days after admission.	N 302		

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

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N 302	Continued From page 1 Findings include: The provider is licensed to care for 20 residents in the client groups irreversible dementia/Alzheimer's disease, and advanced aged. On 02/13/2024, Surveyor reviewed a sample of 4 resident records. Resident 3 was admitted on 08/02/2021 and his/her file included a tuberculosis test administered on 12/08/2021. The results were read on 12/10/2021 and were negative. The file did not include evidence of additional testing within the prior 12 months. No health screening was available to show Resident 3 was screened for communicable disease. Resident 4 was admitted on 10/26/2023 and his/her file included a tuberculosis test administered on 11/29/2023. The results were read on 12/02/2023 and were negative. The file did not include evidence of additional testing within the prior 12 months. The communicable disease screening, dated 11/29/2023, indicated Resident 4 was free from communicable disease. On 02/14/2024, at 5:01 PM, Surveyor requested documentation from Director A and Assistant Director (AD) B via email. On 02/16/2024, at 3:26 PM, AD B submitted additional documentation via email. When asked if Resident 3 completed a health screen or TB test prior to admission, AD B stated, "Yes." When asked if Resident 4 had completed a health screen or TB test prior to admission, AD B stated, "No."	N 302		

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N 302	Continued From page 2 On 02/19/2024, Surveyor requested the health screen and TB test for Resident 3, as AD B indicated it had been completed prior to admission. At 4:29 PM, Director A submitted a tuberculosis test for Resident 3, with an administration date of 12/08/2021 and a read date of 12/10/2023. It appeared to be the same document already provided to the surveyor. On 02/21/2024, at approximately 1:00 PM, Surveyor interviewed Director A and Director E. Surveyor informed Director A and Director E of the health screen and TB test findings for Resident 3 and Resident 4. When asked what the provider's process was for completing resident health screens and TB testing, Director A stated that it should be done within 7 days upon admission. The provider did not ensure Resident 3 and Resident 4 were screened for communicable disease, including tuberculosis, within 7 days after admission. Resident 3's test was completed approximately 4 months after admission and Resident 4's test was completed approximately 1 month after admission.	N 302		
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.	N 386		

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N 386	Continued From page 3 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 develop an individualized service plan (ISP) for Resident 2 to identify his/her needs, desired outcomes, program services, frequency, and approaches, regarding behaviors. Findings include: On 07/19/2023, the Department received a complaint regarding behavior management. On 02/13/2024, at approximately 11:10 AM, Surveyor requested records for Resident 2. RECORD REVIEW Resident 2 was admitted to the facility on 02/03/2023, with a diagnosis of Alzheimer's Disease and dementia. Surveyor reviewed Resident 2's staff observation notes from February 2023 and March 2023, which documented the following: 02/05/2023 at 1:45 PM, "Resident wandering all shift, going in and out of other resident's doors. Resident was trying to lift wheelchairs of other residents with them still in it, and [he/she] was taking other resident's drinks and food from them as well as getting handsy [sic] with staff and	N 386		

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N 386	Continued From page 4 putting [his/her] hands in staff's face and grabbing the back of their neck and not respecting personal boundaries of staff or residents." 02/13/2023 at 5:30 PM, stated Resident 2 had been very aggressive with other residents and had been kicking them. It stated Resident 2 grabbed staff's wrists and almost broke staff's arm. 02/21/2023 at 5:30 PM, "Resident has pulled down pants in dining room during supper 6 times, [sic] staff continues to remind [him/her] that [s/he] has to keep [his/her] pants on outside of [his/her] room." 02/23/2023 at 4:00 PM, " ...Resident then grabbed on the RCA [Resident Care Assistant] and dug [his/her] nails into skin leaving a mark. [S/he] then punched RCA two times in the arm." Other staff observations indicated physical and verbal aggression on 2/16/2023, 2/18/2023 and 2/19/2023. Surveyor was provided a copy of Resident 2's 30-Day ISP with no date indicated and no signatures. On 02/19/2024, Surveyor requested Resident 2's most updated ISP, any elopement assessments completed, and additional incident reports via email. On 02/20/2024, Assistant Director (AD) B submitted another copy of Resident 2's 30-Day Assessment completed on 03/03/2023, that was not signed. That copy appeared to be identical to the first copy provided to Surveyor. Additional incident reports provided included the following:	N 386		

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N 386	Continued From page 5 Resident Event Report, dated 02/23/2023, stated, "Staff was trying to redirect resident out of another resident's room when resident yelled [expletives], put [his/her] hands around staff members neck, and slammed them against the wall. Staff was able to pry hands off of neck and had to yell for assistance to redirect resident out of the room." The resident event report indicated the ISP was updated, significant change of condition was initiated, and a negotiated risk form was initiated/updated. The 30-Day ISP, dated 03/03/2023, under the subsection titled, "Resident Frequently Disrobes," the box was left blank. Under the section titled, "Psychological Well-Being," with a subsection titled, "Wandering/Elopement," it stated Resident 2 was scored a 0 and had no problem with wandering or elopement. Under the "Orientation/Behaviors" section, with a subsection titled, "Shows signs of verbal and/or physical abuse to others," Resident 2 was scored a 0 with no supervision needed. Resident 2's 30-Day ISP was not accurate and complete in areas related to wandering, verbal and physical aggression and disrobing. The ISP did not give staff direction on how to redirect Resident 2's behavior when s/he engaged in wandering, disrobing and verbal and physical aggression toward staff and residents. Staff observation notes between March 2023 and June 2023 identified the following: -Seven elopement attempts staff were able to redirect. -Approximately 15 incidents when Resident 2 was incontinent of urine or bowel on the facility flooring.	N 386		

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-Six incidents when Resident 2 disrobed in an area outside of his/her bedroom where s/he could be observed by other residents.
-Two incidents when Resident 2 had flooded his/her room and nearby hallway by leaving the water running in his/her room sink. The flooring had been "saturated with a large amount of water."

Surveyor reviewed Resident 2's medication administration record (MAR). The April 2023 and May 2023 MARs indicated the following medication orders:

-Haloperidol 2 mg/ml, 1ml by mouth every 6 hours as needed (PRN) for agitation, start date: 04/20/2023, end date: 05/02/2023.
-Haloperidol 2 mg/ml, 2mls by mouth every 6 hours as needed for agitation, start date: 05/05/2023, end date: 05/08/2023.

The May 2023 MAR did not demonstrate Haloperidol was available on May 3 or May 4. There was not an active order observed in the record.

The ISP was updated with the header of the document titled, "RN Review and Update" and signed by a registered nurse on 05/02/2023. Under the medication section of the ISP, it read, in part, "Resident is taking the following psychotropic medications, Paroxetine-scheduled daily for Agitation. Quetiapine-scheduled daily for alzheimer [sic] disease. 4/3/23 - Resident is prescribed scheduled Olanzapine for insomnia 5/2/2023 Quetiapine has been discontinued. Resident is prescribed PRN (as needed) olanzapine for agitation. Resident exhibits agitation by becoming physically aggressive with staff and other residents, yelling and trying to

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elope from facility." The ISP did not contain information about Haloperidol and what it was used for.

The ISP was updated with the header of the document titled, "90 Day Assessment: Quarterly Update" and signed by AD B on 05/31/2023. Under the medication section of the ISP it read, in part, "Resident is taking the following psychotropic medications, Paroxetine-scheduled daily for Agitation. Quetiapine-scheduled daily for alzheimer [sic] disease. 4/3/23 - Resident is prescribed scheduled Olanzapine for insomnia 5/2/2023 Quetiapine has been discontinued. Resident is prescribed PRN olanzapine for agitation. Resident exhibits agitation by becoming physically aggressive with staff and other residents, yelling and trying to elope from facility." The ISP did not contain information about Haloperidol and what it was used for. Under the section titled, "Psychological Well Being" with a subsection titled, "Wandering/Elopement," Resident 2 was scored a 0 and indicated s/he had no problem with wandering or elopement. Resident 2 had multiple elopement attempts documented in staff observation notes, with other areas of the ISP confirming wandering and elopement were a concern. There was no staff direction on how to monitor and support Resident 2 with wandering or elopement attempts.

The provider issued a 30-day discharge notice, dated 05/25/2023, and cited concerns with inappropriate toileting and aggressive behaviors. The discharge notice read, in part:

"On February 16, 2023 [Resident 2] nudged another resident, causing an altercation between the two residents and both residents had fists up intending to hit the other. Staff were able to

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intervene and redirect."
"On February 23, 2023 [Resident 2] was in another resident's room when staff tried to re-direct [him/her], [he/she] yelled [expletives] and put [his/her] hands around the team member's neck and shoved staff into the wall."
" ...Since admission, [Resident 2] on average has 2 inappropriate toileting incidents a day, at least 5 days a week, which include urinating on walls, urinating in common areas, urinating on carpet in [his/her] room and attempting to urinate on other residents."

On 02/21/2024, Director E provided updated ISPs for Resident 2 via email. The verbal and physical aggression exhibited by Resident 2 was not captured on the ISP until 04/27/2023. The wandering/elopement section did not capture a risk for wandering or elopement until 06/02/2023. An elopement assessment was completed on 02/03/2023, the date of Resident 2's admission, that indicated Resident 2 was not at risk for elopement. No other elopement assessments were provided for review. On 04/27/2023, the ISP was updated and indicated Resident 2 "refuses to change/wear incontinence products, inappropriate toileting, refuses to be on a toileting schedule, etc." An intervention strategy identified on the ISP stated Resident 2 was on a 2-hour toileting schedule and was previously on a 4-hour toileting schedule. Staff stopped charting a toileting schedule after 04/27/2023.

INTERVIEW

On 02/13/2024, at 1:49 PM, Surveyor interviewed AD B. Surveyor inquired about the provider's behavior management policy and procedure. AD B stated the provider did not have a general behavior management policy and procedure. AD

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B stated those procedures were developed as needed and were resident specific.

At 2:21 PM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 2 would often urinate in various places throughout the facility and came out of his/her room naked. Caregiver D stated Resident 2 would flood his/her room by using the kitchenette sink in his/her room. Caregiver D stated Resident 2's room had carpet flooring that was replaced with hardwood flooring.

At 2:50 PM, Surveyor interviewed Director A, AD B, and Regional Director (RD) C. Surveyor asked about the circumstances that surrounded Resident 2's admission and subsequent 30-day discharge notice. RD C stated Resident 2 had challenging behaviors up until he/she was discharged. RD C stated there was frequent communication with family, hospice, and primary care providers to establish a medication regimen that would support Resident 2. RD C stated hospice monitored Resident 2's medications and made changes as needed.

On 02/16/2024, AD B provided surveyor with additional documentation via email. When asked if Resident 2 had a behavioral support plan, AD B stated, "No." When asked why Resident 2's toileting schedule on staff charting stopped being documented after 04/27/2023, AD B stated, "On 4/27/23, charting was switched from a 2-hour toileting schedule to a PRN, We [sic] are unsure how this happened."

On 02/21/2024 at 1:00 PM, Surveyor interviewed Director A and Director E via conference call. Director A stated Resident 2 was demonstrating verbal and physical aggression within his/her first 30 days of residing in the facility. When asked

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N 386	Continued From page 10 why that was not captured on the ISP, Director A stated s/he did not know. When asked if Resident 2 may have benefitted from having a behavior support plan developed, Director A stated, "Yes." When asked why the ISP was not signed by Resident 2 or his/her legal decision maker, Director A stated they send out a letter along with the ISP to families and legal decision makers offering the option to meet and discuss the ISP. Director A stated they ask families and legal decision makers to sign the document but they do not always get the signature page returned to them. Director A stated Resident 2's legal decision maker refused to sign signature pages because of the discharge notice. The provider did not ensure Resident 2 had a comprehensive ISP that captured his/her needs and desired approaches regarding behaviors. The 30-Day ISP did not indicate his/her verbal and physical aggression or provide direction for staff on how to support those behaviors. The ISP was later updated to include behavior interventions approximately 2 months after Resident 2's admission. Subsequent updates to the ISP did not capture all medications available to support Resident 2's behaviors and did not include interventions to monitor and support in the areas of wandering and elopement.	N 386		
N 507	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure combustible material was stored at	N 507		

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N 507	Continued From page 11 least 3 feet away from the furnace. Findings include: On 02/13/2024, at 10:12 AM, Surveyor observed the facility's utility room, which contained the provider's furnace. There were multiple wall shelves within 3 feet of the furnace that displayed the following combustible materials: -Wall texture in a spray can -2 bottles of latex paint remover -Indoor light fixtures in cardboard packaging -Wax free toilet seal in cardboard packaging -Items in plastic bags stacked upon each other -Yellow extension cord -Toilet twister caps -Toilet fill valve -Metal hardware Surveyor observed combustible materials on the floor, under the wall shelving, within 3 feet of the furnace that included: -2 plastic buckets -Plastic trash can with black plastic tubing inside -Dryer vent cleaning system in cardboard packaging At 2:50 PM, Surveyor interviewed Director A, Assistant Director (AD) B, and Regional Director (RD) C. Surveyor discussed the combustible materials observed within 3 feet of the furnace. RD C stated s/he would have maintenance block off the area to ensure staff did not leave combustible items within 3 feet of the furnace. RD C stated s/he would have maintenance reorganize the furnace room and find another place to store the items.	N 507		

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N 617	Continued From page 12	N 617		
N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the hot water temperatures at faucets used by residents did not exceed 115 degrees Fahrenheit (F). Findings include: The provider is licensed to care for 20 residents in the client groups advanced age and irreversible dementia/Alzheimer's disease. The Bureau of Quality Assurance (BQA) and the Bureau of Assisted Living (BAL) issued, respectively, BQA Memo-98-021 (1998) and DQA publication P-01942 (2017) regarding hot water temperatures. These documents listed hot water temperature thresholds and the harm hot water temperatures can inflict on consumers with physical or psychological conditions that prevent instant recoil from dangerously hot water. This document reaffirms the temperature thresholds listed in BQA Memo-98-021 and DQA P-01942. Exposure to hot water is a potential	N 617		

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environmental danger for clients. Elderly clients and clients with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding, e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability. (DQA publication P-01942, Hot Water Temperatures in Adult Family Homes, 08/2017).

Sustained contact with dangerously hot water can result in second and third degree burns according to the following thresholds:

110 degrees F is 13 minutes,
120 degrees F is 10 minutes,
127 degrees F is 1 minute,
And 130 degrees F is 30 seconds.

On 02/13/2024, at 9:35 AM, Surveyor measured the water temperature in a shared resident bathroom with a walk-in shower. The temperature at the sink faucet was 137.9 degrees Fahrenheit.

At 9:41 AM, Surveyor measured the water temperature in a shared resident bathroom with a whirlpool bathtub. The temperature at the sink faucet was 124.7 degrees Fahrenheit.

At approximately 10:45 AM, Surveyor measured the water temperature in Resident 1's bathroom. The temperature at the sink faucet was 118.7 degrees Fahrenheit.

At 2:50 PM, Surveyor interviewed Director A, Assistant Director (AD) B, and Regional Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013430	A. BUILDING: _____ B. WING _____	C 02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE EAU CLAIRE MEMORY CARE	**733 W HAMILTON AVE EAU CLAIRE, WI 54701**

(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 617	Continued From page 14 (RD) C. Surveyor discussed the water temperature findings. RD C stated s/he would have maintenance assess the water temperature valve and ensure water temperatures were within safe parameters.	N 617		