STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018123	A. BUILDING: _____ B. WING _____	C 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTFORD ESTATES II	111 LONE OAK LANE HARTFORD, WI 53027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 10/02/2023, Surveyor conducted a complaint investigation and standard survey at Hartford Estates II. Four deficiencies were identified. The complaint was unsubstantiated. Census: 6	N 000		
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 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 an assessment of Resident 1's physical and mental condition was completed when there was a change in needs. Resident 1 was not re-assessed when s/he started to self-administer his/her medications. Findings include: On 09/29/2023, Surveyor reviewed Resident 1's	N 381		

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
	0018123	A. BUILDING: _____ B. WING _____	C 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTFORD ESTATES II	111 LONE OAK LANE HARTFORD, WI 53027

(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 381	Continued From page 1 record and identified the following: Resident 1 was admitted on 03/29/2023 with diagnoses including alcohol dependence, major depressive disorder, and post-traumatic stress disorder. Resident 1 was their own legal decision maker. Resident 1's progress notes documented: 09/28/2023: "Resident had [his/her] shower tonight, staff noticed [his/her] groin area is very red and advised resident to make sure [s/he] is using [his/her] cream." Resident 1's individual service plan (ISP) dated 03/29/2023 documented: "Medication management-staff administer-Resident requires staff to manage/administer medications." Resident 1's physician order documented: "Ammonium Lac 12%, apply small amount topically to the affected area daily with a start date of 07/17/2023. Antiseptic 4% Sol, apply small amount topically to the affected area 3x/daily with a start date of 06/10/2023. Clotrimazole 1% cream, apply small amount topically to the affected area (groin) 2x/daily for fungal infection, with a start date of 06/08/2023. Nyamyc 100MU/GM Powder, apply externally 3x/daily as needed, with a start date of 04/26/2023. Zinc Oxide 20% Oin, apply thin layer topically to the affected area 3x/daily, with a start date of 07/17/2023. Diclofenac 1% Gel, apply 2 gams topically 4x/day." A review of Resident 1's September 2023	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018123	A. BUILDING: _____ B. WING _____	C 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTFORD ESTATES II	111 LONE OAK LANE HARTFORD, WI 53027

(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 381	Continued From page 2 medication administration record (MAR) indicated since 09/16/2023, Resident 1 had started self-administering his/her ointments. On 09/29/2023 at 10:40 AM, Surveyor interviewed Med Passer C. Med Passer C stated Resident 1 recently started administering his/her own ointments. Med Passer C located a fax from Resident 1's record to his/her physician dated 09/11/2023 asking for an order allowing Resident 1 to self-administer his/her ointments. The fax was returned on 09/15/2023 with the above medications initialed by Resident 1's physician noting s/he agreed for Resident 1 to self-administer his/her ointments. Surveyor asked if the provider completed a self-administration medication assessment. Med Passer C checked Resident 1's record on the computer and could not locate an assessment. On 09/29/2023 at 2:33 PM, Surveyor interviewed Administrator A regarding Resident 1's missing self-administration medication assessment. Administrator A checked Resident 1's record and could not find an assessment. Administrator A stated s/he spoke to Resident 1 about his/her ointments and educated him/her but did not have documentation of an assessment. Administrator A stated s/he would start to utilize the assessments in their electronic health record (ECP).	N 381		
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	N 410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018123	A. BUILDING: _____ B. WING _____	C 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTFORD ESTATES II	111 LONE OAK LANE HARTFORD, WI 53027

(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 410	Continued From page 3	N 410		

administration of medication and any adverse drug reactions to a licensed practitioner, 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 Resident 1's licensed practitioner, supervising nurse, or pharmacist was notified as soon as possible after Resident 1 continued to refuse their medications. Resident 1's record contained no documentation that his/her physician, nurse, or pharmacist was notified.

Findings include:

09/29/2023, Surveyor conducted a standard survey and reviewed Resident 1's record. The following was found:

Resident 1 was admitted on 03/29/2023 with diagnoses including alcohol dependence, major depressive disorder, and post-traumatic stress disorder. Resident 1 was their own legal decision maker.

Resident 1's progress notes documented:
09/28/2023: "Resident had [his/her] shower tonight, staff noticed [his/her] groin area is very red and advised resident to make sure [s/he] is using [his/her] cream."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018123	A. BUILDING: _____ B. WING _____	C 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTFORD ESTATES II	111 LONE OAK LANE HARTFORD, WI 53027

(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 410	Continued From page 4 Resident 1's individual service plan (ISP) dated 03/29/2023 documented: "Medication management-staff administer-Resident requires staff to manage/administer medications." Resident 1's physician order documented: "Ammonium Lac 12%, apply small amount topically to the affected area daily with a start date of 07/17/2023. Antiseptic 4% Sol, apply small amount topically to the affected area 3x/daily with a start date of 06/10/2023. Clotrimazole 1% cream, apply small amount topically to the affected area (groin) 2x/daily for fungal infection, with a start date of 06/08/2023. Lidocaine 5% patch, apply 2 patches topically 1/daily on in the morning off at bedtime, with a start date of 06/09/2023. Nyamyc 100MU/GM Powder, apply externally 3x/daily as needed, with a start date of 04/26/2023. Zinc Oxide 20% Oin, apply thin layer topically to the affected area 3x/daily, with a start date of 07/17/2023. Diclofenac 1% Gel, apply 2 gams topically 4x/day." Surveyor reviewed Resident 1's Medication Administration Record (MAR) for August and September 2023: August 2023 MAR: Clotrimazole 1% cream, Resident 1 refused 08/09/2023-08/10/2023, 08/24/2023-08/25/2023, and 08/28/2023-08/31/2023. Lidocaine 5% patch, Resident 1 refused 08/09/2023-08/10/2023, 08/13/2023-08/15/2023, and 08/24/2023-08/25/2023.	N 410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018123	A. BUILDING: _____ B. WING _____	C 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTFORD ESTATES II	111 LONE OAK LANE HARTFORD, WI 53027

(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 410	Continued From page 5 Antiseptic 4% Sol, Resident 1 refused 08/09/2023-08/10/2023, 08/24/2023-08/25/2023, and 08/28/2023-08/31/2023. Ammonium Lac 12%, Resident 1 refused 08/09/2023-08/10/2023, 08/24/2023-08/25/2023, and 08/28/2023-08/29/2023. Diclofenac 1% Gel, Resident 1 refused: 8 AM-08/09/2023-08/10/2023, 08/23/2023-08/25/2023, and 08/28/2023-08/29/2023. 12 PM- 08/09/2023-08/10/2023, 08/16/2023-08/17/2023, and 08/28/2023-08/31/2023. 4 PM-08/07/2023-08/08/2023. Zinc Oxide 20% Oin, Resident 1 refused: 8 AM- 08/09/2023-08/10/2023, 08/24/2023-08/25/2023, and 08/28/2023-08/29/2023. 2 PM-08/01/2023-08/02/2023, 08/07/2023-08/10/2023, 08/14/2023-08/16/2023, 08/22/2023-08/23/2023, and 08/28/2023-08/31/2023. September 2023 MAR: Zinc Oxide 20% Oin, Resident 1 refused: 8 AM-09/04/2023-09/06/2023. 2 PM-09/02/2023-09/08/2023 and 09/12/2023-09/13/2023. 8 PM-09/08/2023-09/09/2023. Lidocaine 5% patch, Resident 1 refused 09/04/2023-09/08/2023. Antiseptic 4% Sol, Resident 1 refused 09/04/2023-09/06/2023 and	N 410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018123	A. BUILDING: _____ B. WING _____	C 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTFORD ESTATES II	111 LONE OAK LANE HARTFORD, WI 53027

(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 410	Continued From page 6 09/11/2023-09/12/2023. Ammonium Lac 12%, Resident 1 refused 09/04/2023-09/07/2023 and 09/11/2023-09/12/2023. Diclofenac 1% Gel, Resident 1 refused: 12 PM-09/04/2023-09/07/2023. Surveyor reviewed Resident 1's progress notes for August and September 2023 which did not document that his/her physician, nurse, or pharmacist were notified of Resident 1's continued refusals. On 09/29/2023 at 2:33 PM, Surveyor interviewed Administrator A regarding Resident 1's medication refusals and lack of notification to his/her physician. Administrator A stated s/he was unaware that Resident 1's physician had to be notified of medication refusals after 2 consecutive days. Administrator A noted s/he would provide retraining to staff and add this requirement to their policies and procedures.	N 410		
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 toxic substances were stored in a secured area. Findings include:	N 499		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018123	A. BUILDING: _____ B. WING _____	C 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTFORD ESTATES II	111 LONE OAK LANE HARTFORD, WI 53027

(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 499	Continued From page 7 The provider is licensed to care up to 6 residents in the client groups of advanced age, developmentally disabled, physically disabled, irreversible dementia/Alzheimer's, terminally ill, and traumatic brain injury. On 09/29/2023 at 8:49 AM, Surveyor toured the facility and identified the following: In the resident bathroom near the back of the facility, Surveyor observed an unlocked cabinet with Clorox toilet bowl cleaner, 2 bottles of neutral disinfectant cleaner, and Scrubbing Bubbles bathroom cleaner. In the resident bathroom towards the front of the facility, Surveyor observed an unlocked cabinet with 2 bottles of Clorox cleaner and Bleach spray and 1 bottle of glass cleaner. On 09/29/2023 at 2:33 PM, Surveyor interviewed Administrator A regarding the toxic substances not being secured. Administrator A confirmed the cabinets in resident bathrooms did not have locks. Administrator A noted the expectation is for staff to lock toxic substances in the laundry room so residents at risk are safeguarded.	N 499		
Z 022	50.065(3)(b) COMPLETE BACKGROUND CHECK PROCESS Every 4 years or at any other time within that period that an entity considers appropriate, the entity shall request the information specified in sub. (2) (b) 1. to 5. for all caregivers of the entity.	Z 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018123	A. BUILDING: _____ B. WING _____	C 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTFORD ESTATES II	111 LONE OAK LANE HARTFORD, WI 53027

(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
Z 022	Continued From page 8	Z 022		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Caregiver B's background checks were conducted every four years.

The complete background check is to include the Background Information Disclosure Form (BID), the criminal history search form from the Department of Justice (DOJ), and the information maintained by the Department of Safety and Professional Service (DSPS) regarding a person's credentials (IBIS).

Findings include:

On 09/29/2023, Surveyor reviewed Caregiver B's record. The following was found:

Caregiver B was hired on 07/01/2019. Caregiver B's BID was dated 06/17/2019 and his/her DOJ and IBIS were dated 07/01/2019. Caregiver B's record was missing a complete background check due in 07/2023.

On 09/29/2023 at 2:33 PM, Surveyor interviewed Administrator A regarding Caregiver B's background check. Administrator A stated s/he did not know background checks were due every 4 years. Administrator A noted s/he would run Caregiver B's background check right away.