STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016995	A. BUILDING: _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE OF MONDOVI (THE)	**158 E MAIN ST MONDOVI, WI 54755**

(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 09/21/2023, Surveyor conducted a complaint investigation at The Home Place Of Mondovi. The complaint was substantiated. Two deficiencies were identified. Census: 8	N 000		
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 the individual service plan (ISP) for Resident 1 was comprehensive and included Resident 1 was a 2-person assist for toileting in the evening and early morning. Findings include: On 05/24/2023, the Department received a	N 386		

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
	0016995	A. BUILDING: _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE OF MONDOVI (THE)	158 E MAIN ST MONDOVI, WI 54755

(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 1	N 386		

complaint with allegations that the needs of the residents in the facility were not being met.

This provider is licensed to care for up to 10 residents in the client groups of: advanced age, irreversible dementia/Alzheimer's disease and developmentally disabled.

On 09/21/2023, at approximately 12:30 PM, Surveyor reviewed the resident roster. There were 8 residents listed on the roster.

At approximately 12:45 PM, Surveyor interviewed Administrator A. Surveyor asked Administer A to identify any residents needing a 2-person assist for transferring or toileting. Administrator A stated no residents in the facility needed a 2-person assist for transferring or for toileting.

At approximately 1:00 PM, Surveyor interviewed Caregiver B. Caregiver B stated Resident 1 often required a 2-person assist for toileting on the nocturnal shift. Caregiver B also stated the shift started at 9:45 PM and continued until 5:45 AM. Caregiver B informed Surveyor that Resident 1 needed a 2-person assist at least 2 to 3 times during the night shift and the 2-person assist for Resident 1 was done to ensure Resident 1's safety when being toileted. Caregiver B stated there were times when Resident 1's medication caused Resident 1 to be "unsteady." Caregiver B stated those were the times Resident 1 needed two people to assist him/her with toileting. Caregiver B stated Resident 1 needed this assistance at least once or twice a week.

At approximately 2:00 PM, Surveyor reviewed Resident 1's ISP. Resident 1's ISP did not include information about Resident 1 needing 2-person assistance with toileting during the evening and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016995	A. BUILDING: _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE OF MONDOVI (THE)	158 E MAIN ST MONDOVI, WI 54755

(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 2 early morning hours. The ISP did not contain information about Resident 1 needing the assistance due to being unsteady at times after taking his/her medication. At approximately 2:30 PM, Surveyor shared this information with Administrator A. Administrator A acknowledged Resident 1, at times, needed a 2-person assist when toileting. Administrator A stated that since the facility only had one caregiver on the nocturnal shift, the staff person from the other facility assisted the staff person from this facility. Administrator A acknowledged the information regarding the toileting assistance and the need for a 2-person assist were not mentioned in Resident 1's ISP.	N 386		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure there were sufficient numbers of employees on a 24-hour basis to meet the needs of all residents. Findings include: On 05/24/2023, the Department received a complaint with allegations that the needs of the residents in the facility were not being met. This provider is licensed to care for up to 10 residents in the client groups of: advanced age, irreversible dementia/Alzheimer's disease and	N 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016995	A. BUILDING: _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE OF MONDOVI (THE)	158 E MAIN ST MONDOVI, WI 54755

(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 396	Continued From page 3	N 396		

developmentally disabled.

On 09/21/2023, at approximately 11:30 AM, Surveyor reviewed the employee schedule. Surveyor identified the schedule showed one staff for the facility was on duty for the nocturnal shift for the month of May and June 2023.

On 09/21/2023, at approximately 12:30 PM, Surveyor reviewed the resident roster. There were 8 residents listed on the roster.

At approximately 12:45 PM, Surveyor interviewed Administrator A. Surveyor asked Administer A to identify any residents needing a 2-person assist for transferring or toileting. Administrator A stated no residents in the facility needed a 2-person assist for transferring or toileting.

At approximately 1:00 PM, Surveyor interviewed Caregiver B. Caregiver B stated Resident 1 often required a 2-person assist for toileting at times on the nocturnal shift. Caregiver B also stated the shift started at 9:45 PM and continued until 5:45 AM. Caregiver B informed Surveyor Resident 1 needed a 2-person assist at least 2 to 3 times per shift and the 2-person assist for Resident 1 was done to ensure Resident 1's safety when being toileted. Caregiver B stated there were times when Resident 1's medication caused Resident 1 to be "unsteady." Caregiver B stated those were the times Resident 1 needed two people to assist him/her with toileting. Caregiver B stated Resident 1 needed this assistance at least once or twice a week during the nocturnal shift.

At approximately 2:30 PM, Surveyor shared this information with Administrator A. Administrator A acknowledged Resident 1, at times, needed a 2-person assist when toileting. Administrator A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016995	A. BUILDING: _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE OF MONDOVI (THE)	**158 E MAIN ST MONDOVI, WI 54755**

(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 396	Continued From page 4 stated that since the facility only had one caregiver on the nocturnal shift, the staff person from the other facility assisted the staff person from this facility.	N 396		