STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013818	A. BUILDING: _____ B. WING _____	R-C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE OF MAYVILLE	1071 HORICON ST MAYVILLE, WI 53050

(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 07/02/2024, Surveyor conducted a verification visit at Touchstone of Mayville. Two deficiencies were identified. Two of 2 deficiencies were repeat violations (see Statement of Deficiency (SOD) I87Y15). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 6	{N 000}		
{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 observation, record review, and interview, the provider did not administer medications in the intervals prescribed by a practitioner for 1 of 1 resident. This is a repeat deficiency. See Statement of Deficiency (SOD) I87Y15. Resident 11's Systane (eye drops) were administered after the opened expiration date. Findings Include: On 07/02/2024, at approximately 1:00 PM, Surveyor observed the medication cart with	{N 352}		

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
	0013818	A. BUILDING: _____ B. WING _____	R-C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE OF MAYVILLE	1071 HORICON ST MAYVILLE, WI 53050

(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 352}	Continued From page 1 Assistant Administrator N. Surveyor observed 2 eye drops labeled as Resident 11's: 1 bottle of Systane Ultra labeled as opened 03/14/2024 1 tube of Systane Nighttime labeled as dispensed 04/24/2024, opened and undated Surveyor requested Resident 11's record. "Systane® ULTRA can be used for 1 month after opening as long as the product has not expired. Always check the label for the expiration date." (Source: Systane website, Systane Ultra FAQs, 2022, https://systane.myalcon.com/hk/en-HK/products/systane-ultra (retrieval date - July 02, 2024).) "Discard product 30 days after opening." (Source: Systane website, Systane Ointment Lubricant Eye Ointment Product Information, 2018, https://systane-ca.myalcon.com/ca-en/eye-care/systane/products/systane-nighttime (retrieval date - July 02, 2024).) Resident 11 admitted to the facility 01/29/2018. Resident 11's June 2024 MAR documented: Systane Ultr - Instill 1 drop in both eyes twice a day. Documented as administered. Systane Nighttime - Instill a small amount in both eyes every night at bedtime. Documented as administered. On 07/02/2024, at approximately 1:15 PM, Surveyor interviewed Assistant Administrator N. Assistant Administrator N stated s/he would address the concern immediately by discarding the opened bottle of Systane Ultra and ordering a new tube of Systane Nighttime. Assistant Administrator N stated s/he would discuss the	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013818	A. BUILDING: _____ B. WING _____	R-C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE OF MAYVILLE	1071 HORICON ST MAYVILLE, WI 53050

(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 352}	Continued From page 2 importance of dating eye drops with staff.	{N 352}		
{N 431}	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013818	A. BUILDING: _____ B. WING _____	R-C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE OF MAYVILLE	1071 HORICON ST MAYVILLE, WI 53050

(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 431}	Continued From page 3	{N 431}		

This Rule is not met as evidenced by:
Based on observation, interview and record review, the provider did not monitor the health of 2 of 2 residents.

Resident 1's bowel regimen was not monitored to determine constipation.
Resident 11's oxygen concentrator was not monitored to ensure 2 liters (L) of oxygen flow per physician orders.

This is a repeat deficiency. See Statement of Deficiency (SOD) I87Y15.

Findings include:

Example 1: Resident 1

On 07/02/2024, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the facility, 05/22/2015, with diagnosis including constipation.

Resident 1's "Individual Service Plan (ISP)," dated 09/07/2023, documented:
"Capacity for self-direction: Cannot make needs known."
"Toileting: Toileting schedule - approx. (approximately) every 2 hrs (hours)."
The ISP did not provide any guidelines regarding Resident 1's potential constipation needs.

Resident 1's May, June, and July 2024 Medication Administration Records (MARs) documented:
One small bowel movement (BM) between 05/26 and 05/31
One large BM between 06/01 and 06/09
One small BM between 06/18 and 06/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013818	A. BUILDING: _____ B. WING _____	R-C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE OF MAYVILLE	1071 HORICON ST MAYVILLE, WI 53050

(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 431}	Continued From page 4 No BM between 06/29 to 07/02 The MARs documented that Resident 1 was prescribed as-needed (PRN) milk of magnesium, take 30 milliliters by mouth daily as needed for constipation, and Bisacodyl, remove wrapper and insert 1 suppository rectally daily as needed for constipation. Resident 1 was not administered the PRNs throughout May, June or July 2024. "A general rule is that going longer than three days without pooping is too long. After three days, stool becomes harder and more difficult to pass." (Source: Cleveland Clinic website, Changes In Bowel Habits & What They Mean, September 21, 2023, https://my.clevelandclinic.org/health/symptoms/changes-in-bowel-habits (retrieval date - July 2, 2024).) On 07/02/2024, at approximately 1:30 PM, Surveyor interviewed Assistant Administrator N. Surveyor asked how staff knew when to administer Resident 1's PRN milk of magnesium. Assistant Administrator N stated s/he would follow up with Resident 1's primary physician for guidelines. Example 2: Resident 11 On 07/02/2024, at approximately 11:50 AM, Surveyor observed unsecured oxygen tanks in Resident 11's room. Resident 11's concentrator had been moved to the dining room, the other side of his/her bedroom wall. Surveyor noted the concentrator was set at 2.5L. On 07/02/2024, Surveyor reviewed Resident 11's record. Resident 11 admitted to the facility, 01/29/2018,	{N 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013818	A. BUILDING: _____ B. WING _____	R-C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHSTONE OF MAYVILLE	1071 HORICON ST MAYVILLE, WI 53050

(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 431}	Continued From page 5 with diagnosis including hypoventilation (when one breathes too slowly or shallowly, reducing the oxygen and increasing the carbon dioxide in the blood). Resident 11's hospital "Patient Discharge Instructions," dated 01/06/2024, documented: "Diagnosis: pneumonia, cough, decreased oxygen level" "Discharge Oxygen Instructions: Nasal Cannula 2LNC (liters) at night 3LNC with exertion." Resident 11's ISP, dated 12/04/2023, documented: "Adaptive equipment: oxygen" "Oxygen/Saturation Levels: Continuous oxygen at 2L via canula to maintain level of 85% or above. Contact MD (medical doctor) if saturation level falls below 88%. Staff to check oxygen every morning." On 07/02/2024, at approximately 1:30 PM, Surveyor interviewed Assistant Administrator N. Surveyor stated the concentrator appeared to be set at 2.5L versus 2L. Assistant Administrator N stated s/he would amend the ISP to read 93% to match the physician order. Assistant Administrator N stated s/he would adjust Resident 11's oxygen concentrator.	{N 431}		