STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013220	A. BUILDING: _____ B. WING _____	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER	**4647 MORMON COULEE RD LA CROSSE, WI 54601**

(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 01/03/2024, Surveyor conducted a complaint investigation at Care Center. Data for this survey was collected and reviewed through 01/09/2024. The complaint was substantiated. Two deficiencies were identified. Census: 5	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure a written report was submitted to the Department within 3 working days of when law enforcement was called to the facility as a result of an incident that jeopardized the health, safety, or welfare of Resident 1. On 12/31/2022, law enforcement personnel were called to the facility for Resident 1's behaviors, including suicidal ideation. The findings include:	N 164		

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

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N 164	Continued From page 1 The provider is licensed to care for 10 residents within the client groups of alcohol/drug dependent and emotionally disturbed/mental illness. At approximately 10:00 AM on 01/03/2024, Surveyor requested progress notes for Resident 1 from Program Supervisor (PS) A. Surveyor reviewed a progress note dated 12/31/2022. Surveyor also reviewed this progress note at approximately 9:00 AM on 01/09/2024. The report indicated Resident 1 was wanting to leave the facility and engaged in discussion of how and when s/he was going to end his/her life. Law enforcement and the mobile crisis unit was called by staff. The team arrived and diffused his/her plan of leaving the facility and ending his/her life at midnight. During Surveyor's survey preparation, completed on 01/03/2024, Surveyor did not find evidence of a self-report from the provider. The last self-reports from the provider were sent to the department in 2021. At approximately 11:00:00 AM, Surveyor interviewed PS A and asked if this incident was reported to the department. PS A stated s/he did not know if this was reported to the department. PS A remembered the incident and confirmed law enforcement was in the facility during the late afternoon and early evening on 12/31/2022 due to Resident 1's behaviors. At approximately 9:40 AM on 01/09/2024, Surveyor asked Quality Assurance Manager B if the provider sent a self-report for law enforcement being called to the facility. Quality Assurance Manager B stated the provider did not complete or send a self-report to the department for this incident.	N 164		

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N 352	Continued From page 2	N 352		
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 Resident 1 received an as needed (PRN) medication for approximately 15 days in the dosage and at intervals prescribed by a practitioner. Findings include: On 11/20/2023, the department received a complaint stating residents of the facility were not receiving all medications prescribed. The provider is licensed to care for 10 residents within the client groups of alcohol/drug dependent and emotionally disturbed/mental illness. On 01/03/2024, Surveyor conducted a complaint investigation. At approximately 10:00 AM on 01/03/2024, Surveyor requested progress notes for Resident 1 from Program Supervisor (PS) A. Surveyor reviewed the progress notes and found a progress note dated 01/01/2023. The progress note indicated Resident 1 was addressing feelings of hopelessness and suicidal ideation. Resident 1 asked why his/her PRN medication	N 352		

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N 352	Continued From page 3	N 352		

Quetiapine was still not in the facility. Resident 1 indicated the PRN had not been in the facility since Resident 1 was admitted to the facility. The progress note indicated Resident 1 was admitted on 12/08/2022. A progress note dated 12/08/2022 indicated Resident 1, upon being admitted, asked if his/her PRN Quetiapine was at the facility. Staff replied that it had not arrived at the facility yet. In a progress note dated 12/17/2022, Staff stated the PRN was ready for pick up and they drove to the pharmacy to pick up Resident 1's PRN. Pharmacy staff told provider staff that the PRN was not at this pharmacy but was at a pharmacy in a different city. Staff also stated they could not get the PRN and the prescription may not be completed until Monday because the provider was likely not in the office on the weekend. Surveyor did not find any other progress notes regarding Resident 1's Quetiapine. A review of the Medication Administration Record indicated the medication was not in the facility prior and after 01/02/2023. This would have been approximately 23 days after Resident 1 was admitted.

At approximately 11:00 AM on 01/03/2024, Surveyor asked PS A if she/he recalled the concern with the medication not being in the facility for Resident 1. PS A indicated the medication was Quetiapine and also stated the provider had difficulty getting the prescription filled due to Resident 1 moving to the facility from a different city where the provider prescribed Resident 1's PRN. PS A also stated staff tried to secure the medication for Resident 1 but the staff that were working on getting the medication "dropped the ball."

On 01/09/2024 at approximately 9:40 AM, Surveyor asked Quality Assurance Manager

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N 352	Continued From page 4 (QAM) B, if Resident 1's PRN medication was not in the facility for 15 or more days. QAM B said, "Yes." Surveyor then asked if s/he thought the staff who were to secure the medication for Resident 1 dropped the ball. QAM B said, "Yes."	N 352		