STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017826	A. BUILDING: _____ B. WING _____	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPEN ARMS ASSISTED LIVING	3205 WHEELOCK DRIVE RACINE, WI 53403

(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
M 000	INITIAL COMMENTS On 04/04/2024, Surveyor concluded two complaint investigations at Open Arms Assisted Living. Three deficiencies were identified. Two complaints were substantiated. Census: 4	M 000		
M 550	88.10(3)(b) Privacy Privacy. To have physical and emotional privacy in treatment, living arrangements and in caring for personal needs, including toileting, bathing and dressing. The resident, the resident's room, any other area in which the resident has reasonable expectation of privacy, and the personal belongings of a resident shall not be searched without the resident's permission or permission of the resident's guardian except when there is reasonable cause to believe that the resident possesses contraband. The resident shall be present for the search. This Rule is not met as evidenced by: Based on observation and interview, Resident 1 was not provided with privacy during his/her personal cares. During a tour of the facility, Resident 1 was observed in his/her bed while cares were provided by caregiver. The door to the bedroom was not closed. Surveyor and Home Health Physical Therapist D were in the home as Caregiver B was providing personal cares and the bedroom door was open.	M 550		

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

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M 550	Continued From page 1 Findings include: On 03/27/2024, at approximately 9:23 a.m., Surveyor observed Caregiver B providing personal cares to Resident 1 while s/he was in bed. Caregiver B did not close Resident 1's door. Surveyor and Home Health Physical Therapist D were in the home as Caregiver B was providing personal cares. On 03/27/2024, at approximately 11:36 a.m., Surveyor interviewed Resident 1, who stated the caregivers did not close his/her bedroom door when they provided personal cares to him/her. Resident 1 explained s/he could hear people walking past his/her room while she was undressed. Resident 1 stated, "I feel so embarrassed. I don't know why they don't close the door." On 04/04/2024, at approximately 3:45 p.m., Surveyor informed Licensee H, Administrator A and Chief Operating Officer (COO) C of the findings. COO C reported it was a dignity issue to change a resident or provide cares to a resident without closing the door.	M 550		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be	M 570		

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M 570	Continued From page 2	M 570		

hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability.

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure a safe environment for 1 of 1 resident. The provider schedules 1 staff per-shift. Resident 1 required 2 staff members to safely transfer with a mechanical lift.

Findings include:

On 03/27/2024, Surveyor conducted a complaint investigation. The complaint alleged Resident 1's did not receive adequate supervision in the home, when transferred in a mechanical lift. The provider only scheduled 1 staff member per-shift when Resident 1 required 2 staff members to safely transfer with a mechanical lift.

On 03/27/2024 at 9:30 a.m., Surveyor reviewed Resident 1's record. The following was identified:

-Resident 1's was admitted on 06/08/2023 with diagnoses including lower extremity paraparesis, peripheral neuropathy, anxiety disorder, arthritis, chronic pain, and obesity.

-Resident 1's assessment dated 06/08/2023, indicated Resident 1 is non-ambulatory with arthritis in his/her knees. Resident 1 needs total assist with adaptive equipment: Hoyer."

- Resident 1's ISP dated 07/11/2023, indicated Resident 1 needed full assist using 'Hoyer lift' and 'wheelchair' for mobility and transferring. Under

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Bathing Abilities, Resident 1's ISP read, "Total Care. Staff will Hoyer [Resident 1] to the shower chair and shower him/her two times per week."

On 03/27/2024 at 9:20 a.m., Surveyor interviewed Home Health Physical Therapist (HH PT) D who stated the best practice for a person who is Resident 1's size, is to have two staff people present when transferring Resident 1 with the mechanical lift. HH PT D told Surveyor during many of his/her physical therapy visits, s/he assisted the caregivers in getting Resident 1 out of bed because they were working alone.

On 03/27/2024 at 9:25 a.m., Surveyor observed Caregiver B transfer Resident 1 independently with mechanical lift. As Caregiver B had Resident 1 up in the air, swinging in the sling, HH PT D asked Caregiver B if s/he could assist. Caregiver B stated, "No. I can do it alone. I usually do it by myself."

On 03/27/2024 at 9:30 a.m., Surveyor observed HH PT D telling Caregiver B, "You should always have two caregivers when you transfer this resident with a mechanical lift."

On 03/27/2024 at 9:45 a.m., Surveyor interviewed Licensee H who stated, "Caregivers assist each other with showers. We need two caregivers for the mechanical lift and for [Resident 1]."

On 03/27/2024 at 10:40 a.m., Surveyor interviewed Caregiver E, who stated s/he had mechanical lift training. S/He learned how to keep the residents steady in the sling and when transferring a resident, it required two staff; three if the resident was obese. Caregiver E confirmed s/he had transferred Resident 1 without a second caregiver present. Caregiver E stated, "I think the

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M 570	Continued From page 4 ISP states it's okay." On 03/27/2024 at 11:25 a.m., Surveyor interviewed Resident 1 who stated s/he was transferred approximately 4 times a day; once to get up, once to lay down and get changed, again to get back up and last to go to bed. Resident 1 told Surveyor before s/he moved into this facility; s/he was always transferred with two caregivers. At this facility it is mostly only one caregiver. Resident 1 stated, "It sometimes scares me that I will be dropped." On 03/27/2024 at 1:55 p.m., Surveyor interviewed Administrator A who confirmed Resident 1 needed two caregivers to transfer with the mechanical lift for his/her safety. On 03/27/2024 at 2:27 p.m., Surveyor observed Chief Operating Officer (COO) B telling Caregiver B, "You should always call for assistance when transferring [Resident 1]. It's for everybody's safety. Do not transfer a resident alone with a mechanical lift." On 03/27/2024 at 10:00 p.m., Surveyor received an email from HH PT D with a link to a website titled, "How to Use a Hoyer Lift Safely." Under "Important Safety Considerations", the document read, "Work with another caregiver whenever possible. With two people, one can operate the lift, and the other can support the patients back and make sure they don't slip and fall from the sling." (Source: Mobility Plus. How to Use a Hoyer Lift Safely. November 1, 2023. https://www.mobilitypluscolorado.com/blog/how-to-use-hoyer-lift-safely (Retrieval date: April 09, 2024).) On 04/04/2024, at approximately 3:45 p.m.,	M 570		

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M 570	Continued From page 5 Surveyor informed Licensee H, Administrator A and Chief Operating Officer (COO) C of the findings. COO C stated, "We train staff that mechanical lifts are always with two staff. Since you were here, I have created a 'Patient Handling Contract." I have been labeling mechanical lifts with a notation: "Two Person Transfers."	M 570		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on interview and record review, the facility did not ensure all prescription medications were administered at the correct time as prescribed. Resident 1 did not receive his/her colonoscopy SUPREP medication on time. Resident 1 was scheduled to receive his/her first treatment at 5:00 p.m. and did not receive the first treatment until after 7:30 p.m. Findings include: On 03/27/2024, Surveyor conducted a complaint investigation. The complaint alleged Resident 1's colonoscopy preparation medications were not administered during the time it was due.	M 582		

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M 582	Continued From page 6 On 03/27/2024 at 9:30 a.m., Surveyor reviewed Resident 1's record. The following was identified: Resident 1's was admitted on 06/08/2023 with diagnoses including lower extremity paraparesis, peripheral neuropathy, anxiety disorder, arthritis, chronic pain, and obesity. Resident 1's ISP dated 07/11/2023, on page 3 under "Medication Administration," had a box checked indicating staff administered medications to Resident 1. On 03/27/2024 at 3:30 p.m., Surveyor reviewed Resident 1's medical paperwork from Ascension Digestive Health department. The colonoscopy preparation page labeled, "SUPREP", read, "These instructions are your physician's specific instructions. Follow all steps carefully to ensure a successful prep and procedure." The section labeled, 'One day before your procedure' read, "At 5:00 p.m., pour 1 six-ounce bottle of SUPREP liquid into provided container. Add cold water to the 16-ounce fill line, mix and drink. Continue drinking at least 32 oz clear liquids over the next hour. Important: 2nd dose will be 6 hours prior to appointment arrival time on day of procedure." On 03/27/2024 at 3:40 p.m., Surveyor reviewed Resident 1's flexible sigmoidoscopy report dated 03/15/2024. Under post operative diagnosis, Resident 1's record read, "The endoscope was then introduced into the colon and advanced to the rectosigmoid, after which the procedure was aborted due to the prep quality ... The procedure was terminated ... Prep quality: Poor." On 03/27/2024 at 11:20 a.m., Surveyor interviewed Caregiver B who stated s/he gave Resident 1 the second dose of the colonoscopy prep medication at 4:00 a.m. Caregiver B stated Resident 1 had an emotionally difficult time with	M 582		

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the whole process. Caregiver B stated, "Resident 1 is paralyzed from the waist down and needed to be changed approximately ten times. S/He was crying by the morning time. It was very stressful for him/her."

On 03/27/2024 at 11:20 a.m., Surveyor interviewed Resident 1, who stated. "I was supposed to receive my colonoscopy prep medicine at 5:00 p.m. At 7:00 p.m., I didn't understand why I didn't receive it, so I called [House Manager (HM) F] and asked when I was supposed to get my colonoscopy prep medication. [Caregiver G] was angry at me when I called [HM F]. I knew I needed to start the medication."

On 03/27/2024 at 11:40 a.m., Surveyor interviewed HM F, who stated Resident 1 called him/her around 7:00 p.m. to explain Caregiver G did not administered the colonoscopy SUPREP medication at the scheduled time of 5:00 p.m. HM F stated s/he called Caregiver G around 7:15 p.m. and directed him/her to administer the medication to Resident 1. HM F stated, "[Resident 1] received the medication around 7:30 p.m."

On 04/04/2024, at approximately 3:45 p.m., Surveyor informed Licensee H, Administrator A and Chief Operating Officer (COO) C of the findings. Administrator A acknowledged Resident 1's medication were not administered at the correct time as prescribed.