STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018758	A. BUILDING: _____ B. WING _____	R-C 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING - BLOOMER II	406 PRIDDY STREET B BLOOMER, WI 54724

(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 08/13/2024, Surveyor conducted a complaint investigation, verification visit, and licensure survey at VitaCare Living Bloomer II. Data collection continued through 09/27/2024. The complaint was substantiated. Seventeen deficiencies were identified. Six of 17 were repeat violations (see SOD TR1712, dated 12/05/2022). The deficiency identified in SOD J5JP11 was corrected. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 9	{N 000}		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on observation, interview, and record	N 214		

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

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N 214	Continued From page 1	N 214		

review, the provider did not ensure an administrator supervised the daily operation of the facility, programming, and personnel in a way that ensured residents received proper care and treatment.

Findings include:

The provider is licensed to care for 16 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill.

On 08/13/2024 at approximately 10:00 AM, Surveyor conducted an entrance meeting with Executive Director (ED) B. ED B discussed the provider's management structure, which included an assistant director (AD) and ED at each location. ED B stated AD C and s/he both managed this facility and the facility across the parking lot. ED B stated each facility owned by the licensee had a clinical nurse director (CND) who was responsible for the daily operation of multiple locations. ED B stated the CND was the named administrator for each location but was not typically onsite daily. ED B stated s/he started working for the provider in October 2023 and became ED in the beginning of 2024. ED B stated s/he was handed over "a mess." ED B stated s/he had terminated a few staff in his/her new role and was having a hard time getting new staff.

On 08/13/2024 at 2:20 PM, Surveyor interviewed ED B. ED B stated s/he had not taken the administrator course yet and was not sure if s/he would be able to. ED B stated s/he was responsible for resident services. ED B stated AD C was responsible for scheduling, ordering food, and hiring staff. ED B stated s/he was trying to clean up the mess the previous ED left.

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N 214	Continued From page 2 The survey was prompted by a complaint, a verification visit, and a licensure survey. The complaint was substantiated, and the following issues were identified during the survey: - New employees did not have documented orientation upon hire. - New employees did not receive required training within required time frames. - Residents did not receive all prescribed medications at dosages prescribed by practitioner. - Service plans were not developed with all parties involved. - Staff under 18 years of age did not always have a qualified staff working with them. - The provider did not maintain an accurate employee schedule. - The provider did not make sure residents received personal cares per their care plan. - The provider did not provide a daily activity program that met the needs and interests of the residents. - The provider did not maintain food safety. - The provider did not secure resident records. - Facility environment was not kept clean, comfortable, and homelike. - The provider did not ensure fire drills were conducted at least quarterly. - The provider did not ensure other evacuation drills were conducted at least semi-annually. - Confidential health information was not kept confidential. - Smoke and heat detectors were not tested and maintained monthly. - Water at resident faucets were not maintained at a safe temperature. Cross references:	N 214		

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N 214	Continued From page 3 N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease N0230 DHS 83.19 Orientation N0243 83.21(1)-(3) All Employee Training N0352 83.32(3)(h) Rights Of Residents: Receive Medication N0387 83.35(3)(b) Service Plan Development: Parties Involved N0397 83.36(1)(b) Qualified Staff In Charge, On Duty And Awake N0399 83.36(2) Maintain Current Written Staffing Schedule N0425 83.38(1)(a) Personal Care N0427 83.38(1)(c) Leisure Time Activities N0452 83.41(3)(b) Food Safety N0479 83.42(2) Resident Records Safeguarded N0481 83.43(1) Environment Safe, Clean, And Comfortable N0525 83.47(2)(d) Fire Drills N0526 83.47(2)(e) Other Evacuation Drills N0534 83.48(1)(a) Smoke Detection System N0617 83.55(6)(b) Bath And Toilet Areas: Water Temperature	N 214		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the	N 220		

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N 220	Continued From page 4 screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 4 employees sampled (Caregiver D, Caregiver E, and Caregiver H), were screened for communicable disease prior to working with residents. This is a repeat deficiency. See Statement of Deficiency (SOD) TR1712, dated 12/05/2022. Findings include: On 08/13/2024 at 12:46 PM, Surveyor reviewed employee records. Caregiver D was hired on 10/18/2023. Caregiver D's record contained a communicable disease screen, dated 02/07/2024, and no TB skin test. Caregiver E was hired on 05/08/2024. Caregiver E's record contained a QuantiFERON TB gold lab test done on 05/03/2024. Caregiver E's record also contained a TB risk assessment and symptom evaluation, with no date or signature from a health care provider. Caregiver E's record did not contain a communicable disease screen. Caregiver H was hired on 04/26/2024. Caregiver H's record contained a QuantiFERON TB gold lab test done on 06/06/2024. Caregiver H's record also contained a TB risk assessment and symptom evaluation with no date or signature from a health care provider. Caregiver H's record did not contain a communicable disease screening.	N 220		

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N 220	Continued From page 5 On 09/13/2024 at 9:30 AM, Surveyor interviewed Clinical Nurse Director (CND) A, Executive Director (ED) B, and Assistant Director (AD) C. CND A stated they thought the TB screening was efficient to be following DHS 83 and recently found out this was not correct. CND A stated that currently, they have made corrections to their process with new employees to correct this. ED B stated Caregiver D did have a TB test done upon hire. Surveyor set a deadline to receive documents by the end of the day at 5:00 PM. On 09/13/2024 at 4:59 PM, Surveyor received an email from CND A which included a QuantiFERON TB gold lab test done on 01/15/2024, but the name on the lab test was not Caregiver D's name.	N 220		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the	N 230		

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N 230	Continued From page 6 provider did not ensure 4 of 4 employees sampled (Caregiver D, Caregiver E, Caregiver H, and Caregiver G), received orientation training prior to assuming job duties. This is a repeat deficiency. See Statement of Deficiency (SOD) VQ5G11, dated 05/11/2022. Findings include: On 08/13/2024 at 12:46 PM, Surveyor reviewed employee records. Caregiver D was hired on 10/18/2023. Caregiver D's record contained an orientation checklist with no date or signatures from Caregiver D, supervisor, or registered nurse (RN). Each subject matter did have a checkmark next to it, but no completion date. Caregiver E was hired on 05/08/2024. Caregiver E's record contained a team member general checklist that did not contain evidence of successful completion of the following orientation topics prior to assuming job responsibilities: preventing and reporting resident abuse, neglect, and misappropriation of resident property; needs of the individuals in their care; and recognizing and responding to changes of condition. Caregiver H was hired on 04/26/2024. Caregiver H's record contained a team member general checklist that did not contain evidence of successful completion of the following orientation topics prior to assuming job responsibilities: preventing and reporting resident abuse, neglect, and misappropriation of resident property; needs of the individuals in their care; emergency plans; and recognizing and responding to changes of condition.	N 230		

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N 230	Continued From page 7 Caregiver G was hired on 08/28/2023. Caregiver G's record contained an orientation checklist with no date or signatures from Caregiver G, supervisor, or RN. None of the subject matters had a completion date. On 09/13/2024 at 9:30 AM, Surveyor interviewed Clinical Nurse Director (CND) A, Executive Director (ED) B, and Assistant Director (AD) C. CND A clarified the team member general checklist was used for all employees at the start of their employment and included the orientation checklist.	N 230		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental	N 243		

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N 243	Continued From page 8	N 243		

considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment.
Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group.
Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Caregiver D and Caregiver G completed resident rights training within 90 days of hire.

This is a repeat deficiency. See Statement of Deficiency (SOD) TR1712, dated 12/05/2022.

Findings include:

On 08/13/2024 at 12:46 PM, Surveyor reviewed employee records.

Caregiver D was hired on 10/18/2023. Caregiver D's record included an orientation checklist with no date or signatures from Caregiver D,

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N 243	Continued From page 9 supervisor, or registered nurse (RN). Resident rights did have a checkmark next to it, but no completion date. Caregiver D's record also contained a resident rights document with Caregiver D's signature and dated 02/07/2024, over 90 days after his/her hire date. Caregiver G was hired on 08/28/2023. Caregiver G's educational training transcript contained evidence resident rights training was completed on 02/23/2024, over 90 days after his/her hire date. On 09/13/2024 at 9:30 AM, Surveyor interviewed Clinical Nurse Director (CND) A, Executive Director (ED) B, and Assistant Director (AD) C. CND A clarified resident rights was built into their orientation and part of the syllabus. Surveyor set a deadline to receive documents by the end of the day at 5:00 PM. AD C stated new hires reviewed the resident rights document and signed it upon hire. AD C stated Caregiver C was hired prior to starting this process and his/her resident rights document was signed over 90 days after his/her hire date to correct it. CND A stated s/he would be in touch with their staff training program to make sure all new staff were assigned the correct training, by following DHS 83. On 09/13/2024 at 4:59 PM, Surveyor received an email from CND A. The email did not include a new hire syllabus.	N 243		
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	N 352		

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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 4 of 4 residents (Resident 1, Resident 2, Resident 3, and Resident 4) reviewed received all medications in the dosages and at intervals prescribed by a practitioner.

Resident 1, Resident 2, Resident 3, and Resident 4 did not receive multiple medications as prescribed in June, July, and August 2024.

Findings include:

On 06/10/2024, the Department received a complaint alleging residents were not receiving medications as prescribed.

The provider is licensed to care for 16 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill.

On 08/13/2024 at 11:37 AM, Surveyor requested the records for Resident 1, Resident 2, Resident 3, and Resident 4, including their past 3 months of medication administration records (MAR).

Resident 1

Resident 1 was admitted on 12/14/2023 and had his/her medications managed by the provider.

The August 2024 MAR indicated the following medication was not available in the medication cart for staff to administer, for the following dates

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N 352	Continued From page 11 and times: Vanicream - apply twice daily to both lower legs 08/01/2024 8:00 AM and 8:00 PM 08/02/2024 8:00 AM 08/05/2024 8:00 PM 08/06/2024 8:00 PM 08/07/2024 8:00 PM 08/09/2024 8:00 PM 08/10/2024 8:00 PM 08/11/2024 8:00 PM 08/12/2024 8:00 PM Diclofenac Sodium 1% gel - apply 2 grams topically to affected joints four times daily 08/01/2024 4:00 PM and 8:00 PM 08/05/2024 4:00 PM and 8:00 PM 08/06/2024 4:00 PM and 8:00 PM 08/07/2024 4:00 PM and 8:00 PM. July 2024 MAR indicated melatonin 10 mg capsule was not available for administration on 07/03/2024 at 8:00 PM, 07/07/2024 at 8:00 PM, and on 07/08/2024 at 8:00 PM. The June 2024 MAR indicated the following medication was not available in the medication cart for staff to administer for the following dates and times: Oxybutynin extended release 10 mg - take 1 tablet twice daily 06/02/2024 8:00 PM 06/04/2024 8:00 PM 06/05/2024 8:00 PM 06/09/2024 8:00 PM 06/10/2024 8:00 AM 06/11/2024 8:00 AM 06/12/2024 8:00 AM 06/13/2024 8:00 AM	N 352		

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N 352	Continued From page 12 Atorvastatin 20 mg - take 1 tablet daily 06/09/2024 8:00 PM Melatonin 10 mg capsule - take 1 capsule daily at bedtime 06/26/2024 8:00 PM to 06/30/2024 8:00 PM. The June and July 2024 MAR indicated Vanicream and diclofenac gel were not available for staff to administer numerous times for Resident 1. Resident 2 Resident 2 was admitted to the facility on 11/11/2015 and had his/her medications managed by the provider. The August 2024 MAR indicated the following medications were not available in the medication cart for staff to administer, for the following dates and times: Acetaminophen 500 mg - take 2 tablets two times daily 08/08/2024 8:00 AM and 8:00 PM 08/09/2024 8:00 AM and 8:00 PM 08/10/2024 8:00 PM 08/11/2024 8:00 AM and 8:00 PM 08/12/2024 8:00 AM and 8:00 PM 08/13/2024 8:00 AM - Staff note indicated provider was still waiting for a prescription. Culturelle 10b Cell - take 1 capsule two times daily 08/10/2024 8:00 PM 08/11/2024 8:00 AM and 8:00 PM 08/12/2024 8:00 AM.	N 352		

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An anticoagulation clinic note, dated 08/07/2024, indicated Resident 2 was to receive 18 mg of warfarin on 08/07/2024. The August 2024 MAR indicated Resident 2 did not receive his/her warfarin.

An anticoagulation clinic note dated 08/02/2024, indicated Resident 2 was to receive 12 mg of warfarin daily until next appointment on 08/05/2024. The August 2024 MAR indicated Resident 2 did not receive his/her warfarin on 08/02/2024, 08/03/2024, and 08/04/224.

The July 2024 MAR indicated furosemide 20 mg, furosemide 40 mg, and Culturelle were not available for staff to administer numerous times to Resident 2. The July 2024 MAR indicated the following medication was not available in the medication cart for staff to administer for the following dates and times:

Warfarin 6 mg
07/20/2024 8:00 PM
07/21/2024 8:00 PM

Warfarin 7.5 mg
07/20/2024 8:00 PM
07/21/2024 8:00 PM.

An anticoagulation clinic note, dated 07/03/2024, indicated Resident 2 was to receive 12 mg of warfarin daily until next appointment on 07/17/2024. The July 2024 MAR indicated Resident 2 received 14 mg of warfarin on 07/05/2024 and 07/08/2024, instead of 12 mg. Staff notes on 07/12/2024 and 07/15/2024, indicated Resident 2 was scheduled to receive the wrong dose of warfarin (14 mg instead of 12 mg).

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N 352	Continued From page 14 The June 2024 MAR indicated furosemide 20 mg, furosemide 40 mg, mucus relief, melatonin, and Culturelle were not available for staff to administer numerous times to Resident 2. An anticoagulation clinic note, dated 06/19/2024, indicated Resident 2 was to receive 12 mg of warfarin daily until next appointment on 06/26/2024. The June 2024 MAR indicated Resident 2 received 14 mg of warfarin on 06/24/2024, instead of 12 mg. Staff notes on 06/21/2024, indicated Resident 2 was scheduled to receive the wrong dose of warfarin (14 mg instead of 12 mg). Resident 3 Resident 3 was admitted to the facility on 06/01/2024 and had medications managed by the provider. The July and August 2024 MAR indicated Ibuprofen 400 mg (take 1 tablet daily at 8:00 AM) was not available in the medication cart for staff to administer, on the following dates: 07/10/2024 07/11/2024 07/15/2024 07/17/2024 07/18/2024 07/19/2024 07/22/2024 07/23/2024 07/24/2024 07/29/2024 07/31/2024 08/01/2024 08/02/2024 08/03/2024	N 352		

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N 352	Continued From page 15 08/04/2024 08/06/2024 08/07/2024 08/08/2024 08/09/2024 08/11/2024 08/12/2024. The staff notes indicated the provider was waiting for a prescription for Ibuprofen on 08/03/2024 and 08/06/2024. Resident 4 Resident 4 was admitted to the facility on 10/24/2024 and had medications managed by the provider. The August 2024 MAR indicated the following medication was not available in the medication cart for staff to administer, for the following dates and times: Vitamin C 500 mg - take 2 tablets daily 08/01/2024 8:00 AM Miconazole 100 mg - insert 2 suppositories vaginally at bedtime 08/01/2024 8:00 PM 08/02/2024 8:00 PM 08/03/2024 8:00 PM 08/04/2024 8:00 PM 08/05/2024 8:00 PM 08/06/2024 8:00 PM 08/07/2024 8:00 PM 08/09/2024 8:00 PM 08/10/2024 8:00 PM 08/11/2024 8:00 PM 08/12/2024 8:00 PM	N 352		

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Terazosin 10 mg - take 1 capsule daily at bedtime
08/06/2024 8:00 PM

Amlodipine 10 mg - take 1 tablet once daily
08/05/2024

Atorvastatin 20 mg - take 1 tablet once daily
08/05/2024 8:00 PM
08/06/2024 8:00 PM.

The June and July 2024 MAR indicated triamcinolone 0.05% ointment, miconazole 100 mg vaginal suppository, alendronate 70 mg, and atorvastatin 20 mg, were not available for staff to administer numerous times to Resident 2.

On 08/13/2024 at 9:00 AM, Surveyor interviewed Caregiver G. Caregiver G stated there were numerous medication issues, including not updating the electronic MAR and not removing old medication bubble packs timely.

On 08/13/2024 at 12:12 PM, Surveyor interviewed Caregiver H. Caregiver H stated there was a problem with the main pharmacy. When staff hit the reorder button, the pharmacy did not always receive the notification. Staff now had to also send a fax to the pharmacy when they reordered medications through the system. Caregiver H stated resident medications would run out at times but were usually received by the next morning.

On 08/13/2024 at 2:20 PM, Surveyor interviewed Executive Director (ED) B. ED B stated s/he would do a monthly changeover of medications. ED B stated staff were responsible for letting ED B know if medications were not in the medication cart. ED B stated some medications were put on hold, such as vitamins and diabetic supplies, due

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N 352	Continued From page 17 to the pharmacy not covering them. On 08/22/2024 at 8:30 AM, Surveyor interviewed Clinical Nurse Director (CND) A and ED B. ED B stated that if staff did not notify him/her when medications were getting low or out, s/he would not know. CND A stated staff were perhaps not putting in the correct response when charting and s/he would need to follow up with staff. On 08/30/2024 at 1:51 PM, Surveyor received an email from CND A, which indicated there had not been any medication errors since March 2024. On 09/13/2024 at 9:30 AM, Surveyor interviewed CND A, ED B, and Assistant Director (AD) C. AD C stated some of the medications should have been put on hold, with a reason why. ED B stated Resident 2's miconazole suppository was only ordered for a certain number of days and was not discontinued from the electronic MAR right away. AD C stated the pharmacy would not always change the warfarin dose in the electronic MAR right away, but Resident 2 would receive his/her scheduled dose of warfarin that same day as the anticoagulation clinic would send the evening dose along with him/her back to the facility. CND A stated s/he would be taking over transcribing orders for warfarin moving forward. CND A stated they were going to start auditing staff charting of medication administration more frequently and reeducate staff on expectations of medication charting for consistency. CND A stated there was also a bigger issue with the managed care organization (MCO) covering some of the resident medications that the pharmacy would not fill. The provider did not ensure Resident 1, Resident 2, Resident 3, and Resident 4 received all	N 352		

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N 352	Continued From page 18 medications in the dosages and at intervals prescribed by a practitioner, for numerous medications in June, July, and August 2024.	N 352		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 and the resident's legal representative, as appropriate, were involved in developing the individual service plan (ISP) when ISPs were not available or did not contain the resident or the resident's legal representatives' signatures acknowledging their involvement in, understanding of, and agreement with, the plan. Findings include:	N 387		

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N 387	Continued From page 19 On 09/13/2024 at 11:37 AM, Surveyor requested Resident 1's and Resident 4's ISPs with signature pages. Resident 1 had an admission date of 12/14/2023, and an activated Power of Attorney for Health Care (POAHC). Surveyor requested Resident 1's 30- day comprehensive ISP and did not receive one. The most current ISP, dated 06/06/2024, was not signed or dated by POAHC K or the managed care organization. Executive Director (ED) B had signed it on 06/09/2024. There was a note written underneath ED B's signature that stated, "Verbal confirmation given from [POAHC K] will sign at next visit." Resident 4 had an admission date of 10/24/2023 and was his/her own decision maker. Surveyor requested Resident 4's 30-day comprehensive ISP, which was dated 03/26/2024 (over 150 days from admission date) and not signed by Resident 4. On 08/30/2022 at 1:51 PM, Surveyor received an email from Clinical Nurse Director (CND) A, which indicated they were unable to find a signed 30-Day comprehensive ISP for Resident 1 and Resident 4. The email also contained the Service Plan, Implementation and Revisions Policy and Procedure. The policy and procedure read, in part, "A finalized service plan needs to be in place within 30 days of the start of services. The service plan must include a signature or other authentication by the facility and by the resident documenting agreement on the services provided." On 09/13/2024 at 9:30 AM, Surveyor interviewed CND A, Executive Director (ED) B, and Assistant	N 387		

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N 387	Continued From page 20 Director (AD) C. ED B stated they usually had the resident and guardian and/or POAHC sign the ISP. ED B stated the ISP is either reviewed verbally over the phone with a witness or sent to the guardian/POAHC to be signed. This is now being documented. CND A also acknowledged they were still working with their electronic medical record to print an ISP with the correct date on it. On 09/27/2024 at 3:24 PM, Surveyor interviewed POAHC K. POAHC K stated there was only 1 ISP meeting s/he was present for, on 05/08/2024. POAHC K was aware of an ISP meeting 30 days after Resident 1's admission but was unable to be present. POAHC K indicated s/he had not signed the 30-day ISP. The provider did not have a signed 30-day comprehensive ISP for Resident 1 and Resident 4.	N 387		
N 397	83.36(1)(b) Qualified staff in charge, on duty and awake. The CBRF shall ensure all of the following: 1. An administrator or other designated qualified resident care staff in charge is on the premises of the CBRF daily to ensure the CBRF is providing safe and adequate care, treatment and services. 2. At least one qualified resident care staff is present in the CBRF when one or more residents are present in the CBRF. 3. At least one qualified resident care staff is on duty and awake if at least one resident in the CBRF is in need of supervision, intervention or services on a 24-hour basis to prevent, control or improve the resident ' s constant or intermittent mental or physical condition that may occur or may become critical	N 397		

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N 397	Continued From page 21 at any time including residents who are at risk of elopement, who have dementia, who are self-abusive, who become agitated or emotionally upset or who have changing or unstable health conditions that require close monitoring. 4. At least one qualified resident care staff is on duty and awake if the evacuation capability of at least one resident is 4 minutes or more. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a qualified resident care staff was present when Caregiver M and Caregiver L worked alone in the facility and were under 18 years of age. Findings include: On 06/10/2024, the Department received a complaint alleging there were times when only one staff under 18 years of age was working. The provider is licensed to care for 16 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill. On 08/13/2024 Surveyor reviewed the staff schedule and staff roster. The staff schedule indicated Caregiver M worked alone on 08/02/2024, 08/03/2024. 08/04/2024, and 08/10/2024. On 08/04/2024, the staff schedule indicated Caregiver L and Caregiver M were scheduled to work alone together. The staff roster indicated Caregiver M was hired on 06/29/2023 and Caregiver L was hired on 01/20/2024. Caregiver L had a birthdate indicating s/he was under 18 years of age.	N 397		

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N 397	Continued From page 22 On 08/13/2024 at approximately 9:00 AM, Surveyor interviewed Caregiver G. Caregiver G stated Caregiver I would have to go over to the other facility across the parking lot to pass medications, leaving 1 staff in the facility at times. On 09/12/2024 at 4:25 PM, Surveyor interviewed Caregiver I. Caregiver I stated management, including Executive Director (ED) B and Assistant Director (AD) C, did not help staff on the floor when present in the facility. Caregiver I stated Caregiver M had been left in the facility by his/herself for a whole shift and had to use a sit-2-stand by his/herself to transfer a resident. Caregiver I stated 3 out of his/her 5 shifts on a schedule, s/he would have to work alone and travel between the two facilities to pass medications. On 09/13/2024 at 9:30 AM, Surveyor interviewed Clinical Nurse Director (CND) A, Executive Director (ED) B, and Assistant Director (AD) C. CND A stated Caregiver L just turned 18 years old last week and Caregiver M would turn 18 years old in October 2024. AD C stated they did have a lot of new staff that were training. ED B stated caregivers under the age of 18 years were not able to do Hoyer lift transfers and pass medications. Surveyor requested the waiver sent to the department for Caregiver L and Caregiver M being under 18 years of age with a deadline by 09/13/2024 at 5:00 PM. On 09/13/2024 at 1:09 PM, Surveyor interviewed Caregiver L. Caregiver L stated 1 to 2 times s/he had been left alone while the medication passer went to the other facility to pass medication. On 09/13/2024 at 1:35 PM, Surveyor interviewed Caregiver F. Caregiver F confirmed management	N 397		

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N 397	Continued From page 23	N 397		

did not help staff on the floor during the day shift. Caregiver F stated that last night s/he had to call over the medication passer from the facility across the parking lot to give a resident a PRN (as needed) medication. Caregiver F stated this would happen often and would leave staff less than 18 years of age alone in the facility for up to 1 hour. Caregiver F stated Caregiver M had worked for 1.5 hours alone one night.

On 09/13/2024 at 4:59 PM, Surveyor received an email from CND A, which read, in part, "[Caregiver M] and [Caregiver L] were both minors, however per the Minor Waiver Form ...that minors 'will follow applicable OSHA guidelines for use of mechanical lifts by a minor.' Upon verification, minors are allowed to assist as part of a trained team that is led by an adult employee. If [Caregiver L] and [Caregiver M] were scheduled on the same day - they would never be scheduled together, there would always be an adult with them. If the schedule does not reflect this, this is a learning opportunity for us to ensure that our schedule reflects exactly how staffing was during those hours - but I can assure you with confidence that [AC C] and [ED B] made sure that they were never alone."

CND A stated they always had a medication passer scheduled with staff under 18 years of age but the staff schedule did not reflect that. CND A stated that on the days where the staff schedule indicated Caregiver M worked alone, s/he always had a qualified staff working with him/her. The email read, in part, "I can assure you the expectation is for [ED B] and [AD C] to fill in when there are holes or concerns regarding the minors - they are unfortunately on salary so we have no means of showing them clocking in and out." CND A indicated they were unable to access the

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N 397	Continued From page 24 filing cabinet where Caregiver M's waiver form was located and would send it when able. Surveyor did not receive any further documentation of a waiver for Caregiver M. On 09/16/2024, Surveyor reviewed the department's waiver records and a waiver was found for Caregiver M from the previous owners of the facility. There was no current waiver for Caregiver M. Cross Reference N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule	N 397		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain an accurate staffing schedule. Findings include: The provider is licensed to care for 16 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill. On 08/13/2024 at approximately 10:00 AM, Surveyor requested the staff schedule from March 2024 to present, from Executive Director	N 399		

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N 399	Continued From page 25 (ED) B. On 08/13/2024 at 10:00 AM, Surveyor interviewed ED B. ED B stated there were 2 staff scheduled per shift and staff never worked alone in the facility. ED B stated that one staff would be pulled from the facility across the parking lot to make sure there were 2 staff always working in the facility since there were residents that required 2 staff assistance with transfers. On 08/13/2024 at 2:46 PM, Surveyor requested the staff schedule for the past week. Surveyor reviewed the schedule and noted that on multiple days, only 1 staff was scheduled on a shift. On 09/13/2024 at 9:30 AM, Surveyor interviewed Clinical Nurse Director (CND) A, ED B, and Assistant Director (AD) C. CND A stated ED B and AD C would cover any open shifts to make sure there were 2 staff always in the facility. Surveyor asked where the documentation was to show ED B and AD C's coverage. CND A stated ED B and AD C had not been put on the employee schedule yet to show when they covered a shift and this was something still in progress with their schedule software. On 09/13/2024 at 4:59 PM, Surveyor received an email from CND A which stated, in part, "I can assure you the expectation is for [ED B] and [AC C] to fill in when there are holes or concerns regarding the minors - they are unfortunately on salary so we have no means of showing them clocking in and out. -We have partnered with [staff schedule company] to meet biweekly with [ED B] and [AC C] to ensure the schedule is reflecting all of these	N 399		

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N 399	Continued From page 26 changes to continue to prove to you - I am unable to find proper charting (easily identified) regarding that [ED B] and [AC C] was [sic] there during those open times, but I can assure you those areas were covered -I found during my research, that some staff are not showing their actual hours of clocking in and out - which I will have to reach out to [staff schedule company] directly regarding this so it can show those overlaps if they stayed later or not." The provider did not maintain an accurate staffing schedule.	N 399		
N 425	83.38(1)(a) Personal care. 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: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on interview and record review, the provider did not provide services adequate to	N 425		

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meet Resident 1's needs.

Findings include:

On 06/10/2024, the Department received a complaint about resident cares.

The provider is licensed to care for 16 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill.

On 08/13/2024 at 10:53 PM, Surveyor interviewed Resident 1. Resident 1 indicated s/he did not receive showers twice per week as indicated in his/her individual service plan (ISP). Resident 1 stated showers were given by staff when convenient. Resident 1 stated s/he did not normally refuse showers.

On 08/13/2024 at 12:12 PM, Surveyor interviewed Caregiver H. Caregiver H confirmed Resident 1 was compliant with showers and had a lot of incontinence.

On 08/13/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 12/14/2023. Resident 1 had diagnoses that included intracerebral hemorrhage, diabetes mellitus type with nephropathy, chronic kidney disease stage 2, chronic heart failure, and malignant neoplasm of bladder in remission. Resident 1 had an activated power of attorney for healthcare (POAHC).

The ISP, dated 06/06/2024, indicated Resident 1 needed assistance with bathing 2 days per week.

On 08/28/2024 at 2:04 PM, Surveyor requested via email from the provider, the last 3 months of

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shower charting for Resident 1.

On 08/30/2024 at 1:51 PM, Surveyor received an email from Clinical Nurse Director (CND) A, which included a Resident 1's shower charting. Resident 1 was scheduled to shower at 5:00 AM. The shower charting indicated Resident 1 did not receive a shower on the following scheduled days:

06/14/2024 - "refused"
07/05/2024 - "Could not get resident in the shower tonight, [s/he] was only up one time and slept the whole night." At 10:00 PM, staff charted Resident 1 was sleeping.
07/16/2024 - "not done due to behaviors all night"
07/26/2024 - "asleep"
07/30/2024 - "needs [sic] to be reassigned due to being up all night and behaviors. not [sic] going to wake [him/her] to shower after [s/he] falls asleep after being up all night." At 2:00 PM, staff charted Resident 1 was not on the schedule.
08/06/2024 - "A PRN (as needed) Shower was given to [him/her] by writer the other day, and it was documented."
08/09/2024 - "Resident has been asleep since [s/he] went to bed, and there was only 1 staff in house II after 3AM [sic].".

On 09/12/2024 at 4:22 PM, Surveyor interviewed Caregiver I. Caregiver I stated Resident 1 had been refusing his/her showers. Caregiver I stated staff were expected to reattempt asking Resident 1 and document their attempts. Caregiver I stated showers were charted in two different areas by staff in the electronic medical record but was not sure how consistent staff were with their charting.

On 09/13/2024 at 9:30 AM, Surveyor interviewed Clinical Nurse Director (CND) A, Executive

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Director (ED) B, and Assistant Director (AD) C. CND A stated Resident 1 had a right to refuse a shower. CND A stated it was the expectation staff continued to offer a shower after a refusal. ED B stated s/he gave Resident 1 a shower the other day but was not sure if s/he documented it. CND A stated they would send any additional shower charting by staff. Surveyor set a deadline to receive documents by the end of the day at 5:00 PM.

On 09/13/2024 at 4:59 PM, Surveyor received an email from CND A. The email included some additional staff shower charting. The additional shower charting indicated Resident 1 had a shower on the following days:

06/10/2024
06/15/2024
07/01/2024
08/03/2024.

After reviewing all documentation, Resident 1 had a gap of 6 days between showers, from 07/04/2024 to 07/08/2024. Resident 1 had a gap of 6 days between showers, from 07/11/2024 to 07/18/2024. Resident 1 had a gap of 9 days between showers, from 07/24/2024 to 08/01/2024. Resident 1 had a gap of 6 days between showers, from 08/07/2024 to 08/12/2024.

On 09/13/2024 at 1:35 PM, Surveyor interviewed Caregiver F. Caregiver F stated Resident 1 would refuse showers and Caregiver F would try to reattempt twice. Caregiver F stated Resident 1 would smell and s/he would come in on shift to find him/her soaked, unsure if staff had changed him/her on the prior shift. Caregiver F stated Resident 1 was sometimes just washed up with a

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N 425	Continued From page 30 washcloth by staff if s/he had been incontinent. Caregiver F stated staff would chart if Resident 1 refused his/her shower and pass it on to the next shift. On 09/27/2024 at 3:24 PM, Surveyor interviewed POAHC K. POAHC K stated Resident 1 had voiced some concerns about bathing frequency. POAHC K stated s/he had been visiting and observed staff go help Resident 1 wash up after being incontinent. The provider did not maintain good hygiene for Resident 1 to achieve the highest level of functioning possible when s/he had multiple gaps between showers from July to August 2024.	N 425		
N 427	83.38(1)(c) Leisure time activities. 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: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on interview, observation, and record review, the provider did not ensure a daily activity	N 427		

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program was provided to residents.

Findings include:

The provider is licensed to care for 16 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill.

On 06/10/2024, the Department received a complaint about activities.

On 08/13/2024 at approximately 9:00 AM, Surveyor interviewed Caregiver G. Caregiver G stated the activity calendar was not always followed by staff. Caregiver G stated staff on day shift did not always have time to do the activities due to other tasks assigned, such as passing medications, resident cares, meal preparation, etc.

On 08/13/2024 at approximately 10:15 AM, Surveyor observed an activity calendar posted on a bulletin board in the dining room hallway. The August 2024 activity calendar indicated that on the second Tuesday of the month, there would be morning chat, bird feeders, and bean bag game, scheduled for the day. The calendar did not indicate a specific time for the activities to begin.

On 08/13/2024 at 10:53 AM, Surveyor interviewed Resident 1. Resident 1 stated s/he felt there were not enough activities provided by staff. Resident 1 stated s/he liked to fish and was disappointed there were no community outings offered.

On 08/13/2024 at 12:12 PM, Surveyor interviewed Caregiver H. Caregiver H stated s/he felt residents were not offered enough activities

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due to staff not having enough time with all their other tasks. Caregiver H stated many times residents sit around "bored."

On 08/13/2024 at 2:30 PM, Surveyor interviewed Executive Director (ED) B. ED B stated staff were responsible for doing activities with residents and they did not have designated activity staff. ED B stated staff did not always follow the activity calendar and could be doing more activities with residents. ED B stated some staff were better at conducting activities with residents than others. It was a matter of getting staff to do activities. ED B stated s/he was told once their census increased, they would be able to hire designated activity staff.

From 8:53 AM to 2:54 PM, Surveyor did not observe scheduled activities from the August 2024 activity calendar conducted.

On 08/22/2024 at 8:30 AM, Surveyor interviewed Clinical Nurse Director (CND) A and ED B. CND A stated activities were part of staff's tasks for their shift and should be offering them to residents. CND A stated Assistant Director (AD) C was trying to get more volunteers and usually there were more activities going on during the day.

On 08/30/2022 at 1:51 PM, Surveyor received an email from CND A, which included the July and June 2024 activity calendars. These were an exact copy of the August 2024 activity calendar for each day. CND A indicated s/he was unable to locate calendars from previous months further back due to changing their process recently.

On 09/13/2024 at 1:35 PM, Surveyor interviewed Caregiver F. Caregiver F stated staff on evening shift did not always have time to do the activities

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N 427	Continued From page 33 due to other tasks assigned, such as passing medications, resident cares, meal preparation, etc. On 09/13/2024 at 9:30 AM, Surveyor interviewed CND A, ED B, and AD C. CND A stated they would have to monitor staff to make sure activities were getting done.	N 427		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored under sanitary conditions for the prevention of food borne illnesses. The temperature of the refrigerator was not at or below 40 degrees Fahrenheit.	N 452		

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Refrigerated and frozen foods were not labeled and dated consistently. This had the potential to affect 9 of 9 residents residing in the facility.

This is a repeat deficiency. See Statement of Deficiency (SOD) TR1712, dated 12/05/2022.

Findings include:

On 06/10/2024, the Department received a complaint alleging food was not safely stored.

The provider is licensed to care for 16 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill.

On 08/13/2024 at approximately 9:00 AM, Surveyor interviewed Caregiver G. Caregiver G confirmed food was not always labeled and dated.

On 08/13/2024 at 10:19 AM, Surveyor toured the kitchen. Surveyor observed multiple food items in the freezers and refrigerators that were not labeled or dated. Surveyor also observed temperatures of the freezers and refrigerators and found the following:

Freezer #3
-approximately 3 bags of broccoli with no date
-multiple packages of bread and buns with no date

Refrigerator #1
-multiple pitchers of juice made up with no label or date
-thermometer inside read 45 degrees Fahrenheit

Freezer #2

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N 452	Continued From page 35 -package of opened sweet potato fries with no label or date Refrigerator #1 -large open egg carton had a cracked egg oozing over the carton. On 08/13/2024 at 12:12 PM, Surveyor interviewed Caregiver H. Caregiver H also confirmed food was not always labeled and dated appropriately. According to the Wisconsin Food Code, the Federal Department of Agriculture's Food Code, and ServSafe standards, date marking is necessary to indicate when food must be consumed or discarded. These standards indicate refrigerated, ready to eat (RTE), potentially hazardous food (PHF), and time/temperature controlled for safety (TCS) foods that are removed from manufacturer packaging and/or prepared for consumption must be date marked and discarded within 7 days. Refrigerated, RTE, PHF, and TCS foods prepared and packaged in a food processing plant shall also be date-marked when opened in the facility (date not to exceed 7 days). (Servsafe Coursebook, 7th Ed., 2017, p. 5-23) On 08/22/2024 at 8:30 AM, Surveyor interviewed Clinical Nurse Director (CND) A and Executive Director (ED) B. CND A stated it was expected staff wrote a received and open date on food. ED B stated they did keep a refrigerator and freezer temperature log and would continue to monitor.	N 452		
N 479	83.42(2) Resident records safeguarded. The licensee shall ensure all resident records are	N 479		

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adequately safeguarded against destruction, loss or unauthorized access or use.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure resident records were adequately safeguarded against unauthorized access or use when archived records were located in a storage room that was left unsecured.

Findings include:

The provider is licensed to care for 16 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill.

On 08/13/2024 at approximately 10:45 AM, Surveyor observed the door to the storage room was unsecured. The storage room was located along one of the main hallways, accessible to anyone entering or exiting the facility. Surveyor observed the storage room contained multiple boxes of archived resident records on shelves.

On 08/13/2024 at 1:53 PM, Surveyor observed the storage room containing archived resident records was still unsecured.

On 08/13/2024 at 2:20 PM, Surveyor interviewed Executive Director (ED) B. ED B stated the storage room was to remain secured at all times.

On 09/13/2024 at 9:30 AM, Surveyor interviewed Clinical Nurse Director (CND) A, ED B, and Assistant Director (AD) C. CND A confirmed the storage room should remain secured at all times and did not know why it was not that day.

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N 481	Continued From page 37	N 481		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a living environment that was safe, clean, comfortable, and homelike. This is a repeat deficiency. See Statement of Deficiency (SOD) TR1712, dated 12/05/2022. Findings include: The provider is licensed to care for 16 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill. On 08/13/2024 from approximately 10:13 AM to 2:48 PM, Surveyor toured the physical environment and observed the following: 1. Food grime at bottom of cabinet with cookie sheets. Other kitchen drawers and cabinets had food grime at the bottom of them. 2. The windows at the back of the building had window screens with a hole and another window screen was bent causing a hole. 3. Furnace room towards the back of the building had dead bugs all over the floor. 4. Resident 1's room had light debris on his/her carpet. Resident 1's room smelled of urine.	N 481		

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N 481	Continued From page 38 Surveyor observed soiled clothes sitting on his/her shower chair and stool smeared on his/her toilet. On 08/13/2024 at 12:12 PM, Surveyor interviewed Caregiver H. Caregiver H stated Resident 1 was incontinent and his/her room always smelled like urine. Caregiver H stated maintenance took a long time to address issues. On 08/13/2024 at 2:30 PM, Surveyor interviewed Executive Director (ED) B. ED B stated Maintenance J sprayed for ants a while ago in the furnace room and that was probably what was all over the floor. ED B stated Maintenance J had approximately 11 buildings s/he was responsible for and there could be a delay in issues getting fixed. On 08/22/2024 at 4:12 PM, Surveyor interviewed Maintenance J. Maintenance J stated s/he had 16 buildings for just him/her to maintain, with lots of travel time. Maintenance J stated work orders were put into their electronic system and s/he had to put the orders back in if a job was not completed, so they would continue to show up. Maintenance J acknowledged sometimes s/he would forget to put the work order back in and would forget about the request. On 09/13/2024 at 9:30 AM, Surveyor interviewed Clinical Nurse Director (CND) A, ED B, and Assistant Director (AD) C. CND A stated facility cleaning was already a part of staff tasks and s/he planned to have staff do a deep cleaning of the facility.	N 481		
N 525	83.47(2)(d) Fire drills.	N 525		

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Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not conduct quarterly fire drills.

Findings include:

The provider is licensed to care for 16 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill.

On 08/13/2024 at 11:45 AM, Surveyor reviewed the provider's documentation of quarterly fire drills for 2023 and 2024. There was a documented fire drill for 05/14/2024. The fire drill did not include the individual resident evacuation times and the type of assistance each resident needed for evacuation.

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N 525	Continued From page 40 On 08/28/2024 at 2:04 PM, Surveyor requested via email from the provider, any additional fire drills for 2023 and 2024. On 08/30/2022 at 1:51 PM, Surveyor received an email from Clinical Nurse Director (CND) A which stated, "unable [sic] to locate documents from previous ED (executive director) - looked in [his/her] email; we have since your visit in June (2024) have placed reminders and guidelines in [electronic medical record] for drills to be completed." On 09/13/2024 at 9:30 AM, Surveyor interviewed CND A, ED B, and Assistant Director (AD) C. ED B stated the fire drills in 2023 were an issue with the previous ED.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure it conducted other evacuation drills, such as tornado, flooding, or other emergency/disaster drills, at least semi-annually. This is a repeat deficiency. See Statement of Deficiency (SOD) TR1712, dated 12/05/2022. Findings include: The provider is licensed to care for 16 residents in the client groups of irreversible	N 526		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018758	A. BUILDING: _____ B. WING _____	R-C 09/27/2024

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N 526	Continued From page 41 dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill. On 08/13/2024 at 11:45 AM, Surveyor reviewed the provider's documentation of emergency evacuation drills for 2023 and 2024. There were no documented emergency evacuation drills for 2023 and 2024. On 08/28/2024 at 2:04 PM, Surveyor requested via email from the provider any emergency evacuation drills for 2023 and 2024. On 08/30/2022 at 1:51 PM, Surveyor received an email from Clinical Nurse Director (CND) A which stated, "unable [sic] to locate documents from previous ED (executive director) - looked in [his/her] email; we have since your visit in June (2024) have placed reminders and guidelines in [electronic medical record] for drills to be completed." On 09/13/2024 at 9:30 AM, Surveyor interviewed CND A, ED B, and Assistant Director (AD) C. ED B stated the emergency drills in 2023 were an issue with the previous ED.	N 526		
N 534	83.48(1)(a) Smoke detection system. Except as provided under sub. (2), the CBRF shall have an interconnected smoke detection system pursuant to s. 50.035(2) Stats., and shall have an interconnected heat detection system to protect the entire CBRF so that if any detector is activated, an alarm audible throughout the building will be triggered. This Rule is not met as evidenced by: Based on record review and interview, the	N 534		

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N 534	Continued From page 42	N 534		

provider did not ensure the smoke detectors had been tested at least every other month by staff. This had the potential to affect 9 of 9 residents.

Findings include:

The provider is licensed to care for 16 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill.

On 08/13/2024 at 11:45 AM, Surveyor reviewed the provider's documentation of smoke detector tests for 2023 and 2024. There were no documented smoke detector tests for 2023 and 2024.

On 08/28/2024 at 2:04 PM, Surveyor requested via email from the provider, any additional smoke detector tests for 2023 and 2024.

On 08/30/2022 at 1:51 PM, Surveyor received an email from Clinical Nurse Director (CND) A which stated, "unable [sic] to locate document from previous ED (executive director) - looked in [his/her] email; we have since your visit in June (2024) have placed tasks for [ED B] and [Assistant Director (AD) C] to complete within our buildings going forward; attached is our completed task from July."

Surveyor reviewed the attached completed smoke detector test. It was created on 07/03/2024 and completed on 08/08/2024 at 11:15 AM by AD C.

On 09/13/2024 at 9:30 AM, Surveyor interviewed CND A, ED B, and AD C. ED B stated the smoke detector tests in 2023 were an issue with the previous ED.

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N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the hot water temperature at fixtures used by residents did not exceed 115 ° Fahrenheit (F). This had the potential to affect all 9 residents. Findings include: The provider is licensed to care for 16 residents in the client groups of irreversible dementia/Alzheimer's disease, advanced aged, physically disabled, and terminally ill. Based on observation and interview, the provider did not ensure the hot water temperatures in both facility bathroom sinks and kitchen sink did not exceed 115 degrees Fahrenheit (F). Findings include: Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because	N 617		

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these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding, e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability. (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017.)

On 08/13/2024 at approximately 10:15 AM, Surveyor tested the temperature of the water at the sink in the public bathroom. The water temperature was 122.7 degrees Fahrenheit.

On 08/13/2024 at 10:53 AM, Surveyor tested the temperature of the water at the sink in Resident 1's bathroom. The water temperature was 118.9 degrees Fahrenheit.

On 08/13/2024 at 2:30 PM, Surveyor interviewed Executive Director (ED) B about the facility water temperatures. ED B stated they would put in a work order immediately for maintenance to look at it.

On 09/13/2024 at 9:30 AM, Surveyor interviewed Clinical Nurse Director (CND) A, ED B, and Assistant Director (AD) C. CND A stated water temperature checks were done weekly by ED B and they would continue to monitor them.