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	0015617	A. BUILDING: _____ B. WING _____	C 12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT POINT SENIOR LIVING CBRF	8600 COPORATE DR RACINE, WI 53406

(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 12/11/2024, Surveyors completed an abbreviated survey and 3 complaint investigations at Pleasant Point Senior Living CBRF. As a result, 8 deficiencies were identified. Two complaints were substantiated, and 1 complaint was unsubstantiated. Census: 36	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 record review and interview, the provider did not ensure 2 of 2 residents (Resident 1 and Resident 3) reviewed received her/his medications in the dosage and at intervals prescribed by the practitioner. Resident 1 missed 6 doses of rivaroxaban between 09/12/2024 - 09/17/2024. Resident 1 had a stroke and ultimately passed away. Resident 3 missed 11 doses of glargine insulin in October 2024. Findings include: On 10/04/2024, the Department received 2 complaints alleging residents were not receiving prescribed medications.	N 352		

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

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N 352	Continued From page 1 On 01/31/2025, the Department received 1 complaint alleging a resident did not receieve prescribed medications. Record Review On 10/24/2024, at 12:30 PM, Surveyors reviewed Resident 1's record. Resident 1 was admitted on 08/07/2023 with diagnoses including dementia, nonrheumatic aortic valve disorder, hypertension, thyrotoxicosis, hypertrophic cardiomyopathy, and mixed hyperlipidemia. Resident 1's September 2024 medication administration record (MAR) indicated Resident 1 was prescribed rivaroxaban 20 milligrams (mg) once a day for anticoagulants. Resident 1's MAR indicated Resident 1 did not receive her/his rivaroxaban between 09/12/2024 - 09/17/2024. Resident 1's MAR was marked with a "7" on 09/12/2024 - 09/17/2024. Surveyors reviewed the key codes on the back of the MAR, and observed a 7 indicated "Other, see nurses notes". Resident 1's progress notes were as follows: "09/16/2024 monthly wellness note ...there have been no changes to resident's [activities of daily living] or care needs in the past month ..." "09/18/2024 [4:35 AM] ... wellness late entry ... called hospital to follow up on resident, resident was transferred to Froedtert Milwaukee. Will follow up with [child] and hospital once the Dr. [sic] does rounds. Author Wellness Director B." "09/18/2024 [6:04 AM] ... wellness late entry ...resident was check on approx.. [sic] 4:30am [sic] resident was seen having stroke like	N 352		

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symptoms, non responsive [sic] rescue squad was called and resident sent out to Aurora Mt. [sic] Pleasant. [Power of Attorney F] was notified and meeting at the hospital. [Wellness Director B] [Executive Director A] were also notified. Author Wellness Director B."

"09/18/2024 [4:37 PM] ...wellness late entry ... followed up with hospital, resident was in [intensive care unit] intubated. Stable at the moment. Author Wellness Director B."

"09/19/2024 [6:40 PM] ...Move out note late entry ...9/19/24 resident passed away at the Froedtert of Milwaukee ... Author Wellness Director B."

Surveyors did not observe any nurses notes to indicate why Resident 1 did not receive her/his rivaroxaban between 09/12/2024 - 09/17/2024.

Surveyors reviewed pharmacy delivery records. The records indicated 30 tablets of Resident 1's rivaroxaban was delivered to the facility 07/08/2024, 08/13/2024, and 09/16/2024.

On 11/14/2024, at 7:00 AM, Surveyors reviewed Resident 3's record. Resident 3 was admitted on 04/04/2024 with diagnoses including type 2 diabetes with diabetic neuropathy, Alzheimer's, hyperlipidemia, hypothyroidism, major depressive disorder, anxiety disorder and hypertension. Resident 3's October 2024 MAR indicated Resident 3 was prescribed glargine insulin 20 units to be administered twice a day for diabetes.

Resident 3's October 2024 MAR indicated Resident 3 did not receive her/his 4:00 PM dose of glargine insulin on 10/02/2024, 10/13/2024, 10/14/2024, 10/16/2024, 10/17/2024, 10/26/2024, 10/28/2024, and 10/29/2024. Resident 3 did not

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receive her/his 8:00 AM dose of glargine insulin 10/13/2024 - 10/15/2024. On the days Resident 3 did not receive her/his insulin, her/his blood sugar readings were not recorded in the MAR.

Resident 3's MAR was marked with a "7" or "8" on the days Resident 3 did not receive her/his insulin. Surveyors reviewed the key codes on the back of the MAR, and observed a 7 indicated "Other, see nurses notes" and an 8 indicated "Absent from facility". Resident 3's MAR did indicate s/he did receive her/his other medications during the times of the missed insulin administration.

Interviews

On 10/24/2024, at 3:05 PM, Surveyors interviewed Executive Director (ED) A and Wellness Director (WD) B. WD B reported the medication (med) technicians (techs) were responsible for ordering resident medications. WD B reported the med techs should reorder medications when they hit the blue strips on the medication card. WD B confirmed a checkmark in the MAR indicated a resident was administered her/his medications. Surveyors inquired about the lack of notes regarding staff not administering medications, ED A and WD B reported they were working with their electronic MAR (EMAR) system to ensure staff were entering notes if they were not able to administer resident medications and not being able to bypass the note section. ED A and WD B reported they were unaware Resident 1 was out of her/his medications. Surveyors informed ED A and WD B of their findings, ED A and WD B acknowledged Surveyors concerns.

On 12/11/2024, at 3:30 PM, Surveyors interviewed ED A. ED A reported s/he was

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N 352	Continued From page 4 unaware of Resident 3 running out of her/his insulin. ED A reported s/he was unsure if Resident 3 was away from the facility during the times Resident 3 was to be administered her/his insulin. Surveyors inquired about Resident 3 receiving her/his other medications during the PM medication pass, but not her/his insulin. ED A reported s/he was then unsure why those doses were not administered if the other medications were administered. ED A reported they have hired a nurse to assist with this area.	N 352		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address.	N 404		

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N 404	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a physician, pharmacist, or registered nurse conducted an annual review of their medication administration and storage system annually for 1 of 2 years reviewed (2023). Findings include: On 10/24/2024, at approximately 1:00 PM, Surveyors reviewed the provider's medication reviews. Surveyors reviewed a medication review which was dated 11/10/2022. Surveyors did not observe evidence a medication review was completed in 2023. On 10/24/2024, at 1:07 PM, Surveyors interviewed Wellness Director (WD) B. WD B confirmed the code requirement. WD B reported there was not an audit completed in 2023. WD B reported s/he was unsure why the audit was not completed. On 10/24/2024, at approximately 3:00 PM, Executive Director A provided record of email correspondence, dated 10/24/2024, with Doctor of Pharmacy (PharmD) E. PharmD E confirmed an annual review was not completed in 2023.	N 404		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to	N 416		

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N 416	Continued From page 6 non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure injectable medications were administered by non-licensed employees as delegated by a registered nurse. Caregiver C administered prescribed insulin to Resident 2 but was not delegated to administer insulin by a registered nurse. Findings include: On 10/24/2024, Surveyors reviewed Caregiver C's employee record. Caregiver C was hired on 08/09/2024. Caregiver C's record did not contain evidence of nurse delegation. On 10/24/2024, at approximately 2:40 PM, Surveyors reviewed Resident 2's record. Resident 2's physician orders, dated 05/30/2024, indicated Resident 2 was prescribed insulin glargine 8 units to be administered at bedtime. Resident 2's medication administration record (MAR) for October 2024, indicated Caregiver C administered Resident 2's insulin injection on 10/01/2024, 10/16/2024 and 10/22/2024. On 10/24/2024 at 2:44 PM, Surveyors interviewed Executive Director (ED) A. ED A confirmed staff should be delegated before administering injectable medications. ED A reported the nurse had Caregiver C scheduled for medication delegation but was unable to complete the training.	N 416		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the	N 452		

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N 452	Continued From page 7 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 and served under sanitary conditions for the prevention of food borne illnesses, which had the potential to affect 36 of 36 residents residing in the facility. Food items requiring refrigeration were stored in the pantry. Findings include: On 10/24/2024, at 10:35 AM, Surveyors toured the facility's kitchen and observed the following: Pantry: - 2 open bottles of soy sauce, labeled "refrigerate after opening" - 1 open container of parmesan cheese, labeled "refrigerate after opening"	N 452		

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N 452	Continued From page 8 - 1 open jar of orange marmalade, labeled "refrigerate after opening" - 1 unsealed storage container, labeled "flour" - 3 open bottles of yellow mustard, labeled "refrigerate after opening" - 1 open container of thousand island dressing, labeled "refrigerate after opening" - 1 open bucket of chocolate fudge icing, labeled "refrigerate after opening" - 1 unsealed bag of dry noodles - 1 open container of ranch dressing, labeled "refrigerate after opening" - 2 open bottles of lemon juice, labeled "refrigerate after opening" - 1 unsealed bag of powdered cheddar cheese Dining Rooms: - 6 open bottles of yellow mustard, labeled "refrigerate after opening" "Refrigeration slows bacterial growth. Bacteria exist everywhere in nature. They are in the soil, air, water, and the foods we eat. When they have nutrients (food), moisture, and favorable temperatures, they grow rapidly, increasing in numbers to the point where some types of bacteria can cause illness. Bacteria grow most rapidly in the range of temperatures between 40 and 140 °F, the 'Danger Zone,' some doubling in number in as little as 20 minutes. A refrigerator set at 40 °F or below will protect most foods." (Source: USDA.gov, Refrigeration & Food Safety, March 23, 2015, https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/refrigeration (retrieval date: 01/09/2025).) On 10/24/2024, at 3:05 PM, Surveyors interviewed Executive Director (ED) A and Wellness Director (WD) B. ED A and WD B	N 452		

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N 452	Continued From page 9 reported Dietary Supervisor (DS) G was responsible for management of the food storage and performed daily audits of the food. ED A and WD B acknowledged Surveyors' concerns with food storage at the facility.	N 452		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were securely stored in 4 of 4 areas. Cleaning compounds were not securely stored in the kitchen, laundry room, salon, and mechanical room. Findings include: The facility is a Class CNA (non-ambulatory) Community Residential Facility and may serve up to 44 residents in the client groups of advanced aged and irreversible dementia/Alzheimer's. On 10/24/2024, at 8:35 AM, Surveyors toured the facility and observed the following: Kitchen: The kitchen contained 2 Dutch style doors on west and east end of the kitchen. Both doors opened into dining rooms in the west and east side of the facility. The open doors contained locking mechanisms, which were engaged, but	N 499		

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not secured. On the counter was a container of Great Value disinfecting wipes, a bottle of Odoban disinfectant fabric & air freshener, and a spray bottle with a purple liquid labeled sanitizer. Two lower cabinets on the west side of the kitchen did not contain locking mechanisms. Inside the cabinets were 2 bottles of TMA pot & pan detergent, a can of Array stainless steel polish, a bottle of Stem ant, roach and fly spray, a can of Lysol disinfectant spray, a spray bottle of a clear liquid labeled dish spray, and 3 bottles of Fabuloso multipurpose cleaner.

Laundry Room:

The laundry room door appeared closed, but when Surveyors pushed on the door, the door opened. Surveyors tested the door lever, the locking mechanism was engaged, but the door would not latch in the strike plate. Inside the laundry room was 6 bottles of Medline heavy duty bowl cleaner, a bottle of Chemworx all-purpose cleaner, and 2 bottles of Chemworx hydrogen peroxide cleaner.

Salon:

The salon door contained a locking mechanism. The locking mechanism was not engaged. In a cupboard drawer was a bottle of Hydrox germicide disinfectant and a bottle of Roux fanci-full hair color rinse.

Mechanical room:

The mechanical room door contained a locking mechanism. The locking mechanism was not engaged. Inside the mechanical room was a bottle of Odoban heavy-duty purple degreaser, a bottle of TMA bio-suds enzyme detergent, bottle

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N 499	Continued From page 11 of CLR, USG Plus 3 joint compound, bottle of Zep grease clog dissolver, container of Dap kwik seal silicone sealer, and a can of Homax wall texture. On 10/24/2024, at 3:05 PM, Surveyors interviewed Executive Director (ED) A and Wellness Director (WD) B. ED A and WD B confirmed the code requirement. ED A reported s/he would ensure all chemicals were securely stored. ED A reported s/he thought the kitchen was okay because staff were in the kitchen. Surveyors informed ED A unless staff were actively using them, chemicals needed to be securely stored at all times. ED A acknowledged s/he understood.	N 499		
N 507	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure combustible materials were not placed within 3 feet of facility furnaces and water heaters in 1 of 1 utility room. Combustible materials were stored within 3 feet of the facility's furnaces and water heaters. Findings include: On 10/24/2024, at 11:37 AM, Surveyors toured the mechanical room. Surveyors observed the following: A furnace filter was set onto ducting, 2 inches from the furnace. Two wood shelf boards were 22	N 507		

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N 507	Continued From page 12 inches from the furnace. Four closet doors were propped up against the wall and furnace. A plastic bag was 3 inches from the furnace. One wood shelf board was 19.5 inches from the furnace. Window screens were stacked 23 inches from the furnace. A wheeled plastic cart, which contained paint buckets and a drop cloth, was 16.75 inches from furnace 1 and 33.5 inches from furnace 2. On 10/24/2024, at 3:05 PM, Surveyors interviewed Executive Director (ED) A and Wellness Director (WD) B. ED A and WD B acknowledged Surveyors' concerns with combustibles material storage within the utility room. ED A and WD B did not offer any further information.	N 507		
N 525	83.47(2)(d) Fire drills. 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.	N 525		

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure quarterly fire drill reports documented a total evacuation time for 7 of 7 quarters, in calendar years 2023 and 2024. The provider did not evacuate the residents from the building during quarterly fire drills, therefore the provider was unable to accurately document a total evacuation time for the fire drills.

Findings include:

The facility was licensed as a Class CNA (non-ambulatory) Community Residential Facility able to serve up to 44 residents in the client groups of advanced aged and irreversible dementia/Alzheimer's.

On 10/24/2024, at approximately 12:20 PM, Surveyors reviewed the facility's safety records and identified the following:

The fire drill records reported fire drills were conducted on the following dates and times:

05/30/2023, at 11:45 AM
08/16/2023, at 4:00 AM
10/26/2023, at 4:15 [AM/PM]
11/15/2023, at 9:30 AM
01/31/2024, at 5:30 AM
04/18/2024, at 1:10 PM
07/30/2024, at 8:00 AM

The records did not include total evacuation time.

On 10/24/2024, at 12:25 PM, Surveyor interviewed Maintenance Director D. Maintenance Director D reported s/he was responsible for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015617	A. BUILDING: _____ B. WING _____	C 12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT POINT SENIOR LIVING CBRF	8600 COPORATE DR RACINE, WI 53406

(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 525	Continued From page 14 completing fire drills and maintaining the records. S/He reported residents were not evacuating the building during a fire drill. The facility had a system in which they closed residents' room doors during the fire drills and utilized a roster to account for each resident. Maintenance Director D reported corporate was in the process of evaluating the fire drill process within the company, due to known issues at sister facilities. Maintenance Director D reported fire drills for 2023 and 2024 did not have evacuation times due to not evacuating residents. Surveyor explained the code requirement of evacuating and recording total evacuation time. Maintenance Director D acknowledged her/his understanding. On 10/24/2024, at approximately 3:35 PM, Surveyors interviewed Executive Director A. Surveyor inquired how the facility was completing fire drills. Executive Director A reported Maintenance Director D gave a warning to the fire department, staff monitored the length of time it took for residents to evacuate, and staff would meet after the drill was completed. Executive Director A reported s/he did not know an evacuation of residents was not being conducted during the fire drills.	N 525		
N 535	83.48(1)(b) Smoke and heat detectors per NFPA 72. Smoke and heat detectors shall be installed and maintained in accordance with NFPA 72 National Fire Alarm Code and the manufacturer ' s recommendation. Smoke detectors powered by the CBRF ' s electrical system shall be tested by CBRF personnel according to manufacturer ' s recommendation, but not less than once every other month. CBRFs shall maintain	N 535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015617	A. BUILDING: _____ B. WING _____	C 12/11/2024

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N 535	Continued From page 15 documentation of tests and maintenance of the detection system. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure smoke detectors were tested by community based residential facility (CBRF) personnel according to the manufacturers' recommendation, but not less than once every other month in the calendar years 2022, 2023, and 2024. Findings include: The facility was licensed as a Class CNA (non-ambulatory) Community Residential Facility able to serve up to 44 residents in the client groups of advanced aged and irreversible dementia/Alzheimer's. On 10/24/2024, at approximately 12:20 PM, Surveyors reviewed the facility's safety records. The records did not include documentation of smoke detector testing at least once every other month for calendar years 2022, 2023, and 2024. The records included smoke detector testing in February 2024 and March 2024. On 10/24/2024, at 3:33 PM, Surveyor interviewed Maintenance Director D. Maintenance Director D reported smoke detector testing was completed 4 times per calendar year, during the fire alarm testing. Maintenance Director D was unaware of the requirement testing needed to be completed not less than once every other month.	N 535		