| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0014821 | A. BUILDING: _____ B. WING _____ | R 07/20/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HILLTOP VIEW OF FREDONIA INC | 130 MEYER AVE FREDONIA, WI 53021 |

| (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<br><br>On 07/19/2023, Surveyor conducted a verification visit at Hilltop View of Fredonia Inc. Additional information was gathered through 07/20/2023. As a result, all previous deficiencies were corrected and one new deficiency was identified.<br><br>Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed.<br><br>Census: 7 | {N 000} | | |
| N 419 | 83.37(3)(c) Medication storage: locked cabinet.<br><br>Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF.<br><br>This Rule is not met as evidenced by:<br>Based on observation and staff interview, the provider did not ensure 7 of 7 residents' medications were securely stored.<br><br>Findings include:<br><br>The facility is licensed to provide services for up to 7 residents who may be developmentally disabled, physically disabled, advanced age, emotionally disturbed/mental illness, traumatic brain injury and/or irreversible dementia/Alzheimer's. The census at time of survey was 7.<br><br>On 07/19/2023, Surveyor entered the facility at approximately 11:30 AM. Surveyor observed Caregiver A working alone and the medication cart was unlocked. At approximately 11:40 AM, Caregiver A walked to the medication cart and gave Resident 4 a smoking cartridge. Caregiver A walked away from the medication cart and left it | N 419 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| HILLTOP VIEW OF FREDONIA INC | 130 MEYER AVE FREDONIA, WI 53021 |

| (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 419 | Continued From page 1<br>unlocked. Surveyor observed Resident 4 walk around the facility. At 12:00 PM, two caregivers (Caregivers A and B) were both present and working in the building. At approximately 12:05 PM, Surveyor walked over to the medication cart, opened the drawer and observed resident medications in the medication cart. Surveyor asked Caregiver A if s/he had a key to the medication cart and Caregiver A stated yes s/he did. Caregiver B prompted Caregiver A to walk over to the cart and push the button to lock the cart.<br><br>On 07/20/2023 at 9:03 AM, Surveyor exited with Owner C. Owner C acknowledged the medication cart should be locked at all times to keep the medications secured.<br><br>The provider did not keep all medications locked/secured. | N 419 | | |