STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015388	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN FIELDS	E426 CO RD SS LUXEMBURG, WI 54217

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N 000	Initial Comments On 04/22/2025, with information gathered through 04/23/2025, Surveyor investigated 2 complaints at Autumn Fields. As a result of the investigation, 2 of 2 complaints were substantiated and 3 new deficiencies were identified. Census: 19	N 000		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure caregiver background checks were conducted and documented at the time of hire for 1 of 2 caregivers reviewed (Caregiver D). Findings Include: On 04/07/2025, the department received a complaint alleging the provider was not	N 219		

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

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N 219	Continued From page 1 conducting background checks. On 04/22/2025, at approximately 10:15AM, Surveyor requested a staff roster and Caregiver D and Caregiver E's record pertaining to background checks from Administrator A. At approximately 1:25PM, Administrator A provided the requested documentation. Administrator A informed Surveyor s/he could not locate Caregiver D's background check, only the completed Background Information Disclosure (BID). On 04/22/2025, at approximately 1:30PM, Surveyor reviewed Caregiver D's BID and noted it was completed on 09/18/2024. There was no evidence or documentation the check was ran as required. According to the staff roster, Caregiver D was hired on 09/18/2024. On 04/23/2025, Administrator A informed Surveyor s/he completed Caregiver D's background check on 04/22/2025. Administrator A reported s/he will review other caregiver files to ensure background checks are completed.	N 219		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency	N 277		

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N 277	Continued From page 2 procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure caregivers received at least 15 hours per calendar year of continuing education that included standard precautions, client groups, medications, resident rights, prevention and reporting of abuse, neglect and misappropriation and fire safety and emergency procedures, including first aid for 1 of 2 caregivers reviewed (Caregiver E). Findings Include: On 04/07/2025, the department received a complaint alleging caregivers were not receiving continuing education. On 04/22/2025, at 9:43AM, Surveyor interviewed Caregiver E. Caregiver E identified s/he currently works as a medication passer and caregiver. On 04/22/2025, at 4:00PM, Surveyor reviewed the provider's staff roster. The roster noted Caregiver E was hired on 12/04/2023. Surveyor reviewed Caregiver E's continuing education records for 2024. Surveyor noted there was no documented training in the following required areas: fire safety, first aid and choking, client group or medications. Additionally, the training hours added up to 8.5 and not 15 as required. On 04/23/2025 at 1:00PM, Surveyor interviewed Administrator A. Administrator A acknowledged the findings and reported s/he will ensure continuing education contains the required	N 277		

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N 277	Continued From page 3 subject areas.	N 277		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure there were employees in sufficient numbers on a 24-hour basis to meet the needs of the residents for Resident 1. Findings Include: On 04/04/2025 and 04/07/2025, the department received complaints alleging there was not enough staff to meet resident needs. On 04/22/2025, at 8:41AM, Surveyor interviewed Caregiver B. Caregiver B explained on 03/25/2025, s/he came in for the morning shift at 6:00AM. Caregiver B identified Caregiver C worked the overnight shift. Upon arrival, Caregiver C told Caregiver B Resident 1 needed to be transferred from the recliner to the bed. Caregiver C disclosed to Caregiver B s/he could not do this during his/her shift because s/he was the only caregiver in the building. Caregiver B explained Resident 1 was declining and needed assistance of two caregivers for transfers. Caregiver B went to Resident 1's room and observed Resident 1 siting in his/her recliner with a blanket and was incontinent of bowel. Resident 1 informed Caregiver B that Caregiver C said s/he would have to "wait until the morning" for transfer assistance because Caregiver C was the	N 396		

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N 396	Continued From page 4 only caregiver there. At 6:00AM, when Caregiver B arrived, Caregiver B and Caregiver C transferred Resident 1 to the bed and cleaned him/her up. Note: Resident 1 was not available to be interviewed as s/he passed away on 04/06/2025. On 04/22/2025, at 9:55AM, Surveyor interviewed Administrator A. Administrator A explained there was a second staff scheduled to work the overnight shift on 03/24/2025 into 03/25/2025. The second caregiver had his/her schedule mixed up and did not show up for the shift. Administrator A reported there are two staff that live very close to the building. Administrator A confirmed Caregiver C worked the overnight shift on 03/24/2025 into 03/25/2025 alone. The direction given to Caregiver C was to call one of caregivers that live close by if s/he needed assistance during the shift. Administrator A explained caregivers informed him/her of the situation and s/he completed an investigation. Administrator A stated the investigation confirmed Caregiver C did not call either of the caregivers for assistance and chose to leave Resident 1 in the recliner. Administrator A stated Resident 1's 2-hour checks were recorded in the medication administration record (MAR) as completed throughout the shift. During the investigation, Caregiver C identified Resident 1 was not incontinent during his/her shift. Administrator A stated s/he could not confirm if the incontinence occurred during the overnight shift, or between the time of the last documented check and the morning shift's arrival. Administrator A advised s/he submitted the investigation to the department for review.	N 396		

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N 396	Continued From page 5 On 04/22/2025, at approximately 10:15AM, Surveyor reviewed Administrator A's investigation dated 03/26/2025. The investigated noted the following: >On 03/25/2025, Administrator A was informed Resident 1 was left alone from midnight to 6:00AM and was incontinent of bowel. >Resident 1 told Administrator A s/he was administered Tylenol at 12:01AM and requested to be transferred from the recliner to bed. Caregiver C told Resident 1 s/he could not transfer him/her as s/he was the only one working. >" Resident 1 mentioned that no one returned till 6:03AM when they had walked in and found Resident 1 ..." >A second caregiver that was scheduled to work the overnight shift did not arrive as s/he confused his/her schedule. >After notifying the registered nurse, Caregiver A acknowledged if s/he needed any assistance s/he would call one of the staff that lives close by. >Administrator A reviewed the electronic record system and noted Caregiver C documented 2-hour checks were completed. >Caregiver C was placed on a performance plan and his/her performance will continue to be monitored for 6 months. On 04/22/2025, at approximately 4:05PM, Surveyor reviewed Resident 1's Individual Support Plan (ISP), updated on 03/19/2025 and 03/25/2025. The ISP identified Resident 1 had a diagnosis of rheumatoid arthritis involving both feet, debility (physical weakness), ankylosing spondylitis of unspecified sites in spine and pain, unspecified. The ISP identified Resident 1 required following assistance: >Transferring: "Full assist with one or two staff to	N 396		

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N 396	Continued From page 6 pivot transfer in to wheelchair, recliner, or bed." >Mobility and Walking: "Full assist with one or two staff to pivot transfer into bed, recliner, or wheelchair. Resident 1 had diagnosis limiting his/her ability to stand, walk or transfer. Resident 1's ISP identified s/he required one to two staff to assist with transfers and mobility. On 02/25/2025, at approximately 12:00AM, Resident 1 requested a transfer from the recliner to his/her bed. Caregiver C was the only caregiver working as the second caregiver did not show up for his/her shift. As a result, Resident 1 was not transferred to his/her recliner until approximately 6:00AM when the morning shift caregivers arrived.	N 396		