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	110331	A. BUILDING: _____ B. WING _____	R-C 01/10/2024

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{N 000}	Initial Comments On 01/05/2023, Surveyors conducted a standard survey, 1 verification visit, and 1 complaint investigation. Five deficiencies were identified. Four of 5 deficiencies were repeat violations. See Statement Of Deficiency (SOD) JTYV11, dated 08/01/2023, SOD XXL911, dated 06/16/2022, SOD 1KI812, dated 11/25/2023, and SOD 1KI813, dated 03/18/2021. Two of 2 deficiencies from SOD #JTYV11 dated 08/01/2023 remain uncorrected. The complaint was substantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 30	{N 000}		
{N 388}	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the individual service plan was implemented as written. Resident 3's individual service plan (ISP) was not implemented as written when 1 staff attempted to transfer him/her alone instead of a 2 assist Hoyer transfer. This is a repeat deficiency. See Statement Of	{N 388}		

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

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{N 388}	Continued From page 1 Deficiency (SOD) JTYV11, dated 08/01/2023. Findings include: On 12/07/2023, the Department received a complaint alleging Resident 3's ISP was not followed as written. On 01/05/2024, Surveyor reviewed Resident 3's record. S/he was admitted 04/10/2023. Diagnoses included unspecified dementia, moderate, without behavioral disturbance and other abnormalities of gait and mobility. Facility progress notes dated 12/06/2023-01/06/2024 included: 12/09/2023 12:38 PM- "Late Entry Note Text: Received call from building that RA attempted to transfer resident by self, witness by [family member]. Assured family of follow up, building called, no s/sx of any injury to resident." Facility ISP dated 05/22/2023: In the area of Two Person or Mechanical Lift- "Requires a two-person assist for transferring during: All transfers ...[Resident 3] will transfer with assistance as required through the end of the review period. [Resident 3] will transfer with assistance from two persons for ADLs as required through the end of the review period. Comments: [Resident 3] uses a two assist with gait belt for transfers and a wheelchair for transportation." On 01/08/2024 at 12:08 PM, Surveyor received an ISP dated 12/21/2023 from Executive Director F stating: In the area of Two Person Mechanical Lift: " ... [Resident 3] uses a two assist hoyer [sic] lift for transfers. 9.18.2023: [Resident 3] may transfer with two assist and gait belt and grab bar in the	{N 388}		

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{N 388}	Continued From page 2 bathroom." Hospice Care Plan (not dated) most recently updated 12/05/2023: In the area of Fall Prevention Plan (start dated 03/28/2023): " ...2 person assist [with] gait belt when in bathroom and hoyer [sic] lift when going from wheelchair to bed or recliner ..." On 01/05/2024 at 1:14 PM, Surveyor interviewed Wellness Director B who stated staff did not follow the ISP when s/he attempted to transfer Resident 3 alone from the recliner to the wheelchair using a gait belt. Wellness Director B stated during the transfer Resident 3 lost his/her balance causing the caregiver to land sitting in the chair with Resident 3 sitting on top of him/her so it was not considered a fall. Wellness Director B stated Resident 3 should have been Hoyer transferred by 2 staff from the recliner to the wheelchair, disciplinary action was taken, and all staff were retrained following the incident. On 01/05/2024 at 3:10 PM, Surveyors discussed concern of staff not following Resident 3's ISP when a caregiver attempted to transfer him/her alone with Wellness Director B, Executive Director F, Assistant Executive Director G, and Resident Care Coordinator H. Executive Director F stated they took corrective action immediately the incident.	{N 388}		
{N 408}	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF	{N 408}		

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{N 408}	Continued From page 3 shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure when a psychotropic medication was prescribed on an as needed basis (PRN) for a resident, the resident's individual service plan included the rationale for use and a detailed description of the behaviors which indicated the need for administration of PRN psychotropic medication for 1 of 2 residents reviewed. Resident 4's individual service plan (ISP) did not include rationale for use and detailed description of the behaviors indicating need for PRN risperidone. This is a repeat violation. See Statement OF Deficiency JTYV11, dated 08/01/2023. Findings include:	{N 408}		

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{N 408}	Continued From page 4 Per DHS 83.02(41) "Psychotropic medication means a prescription drug, as given in s. 450.01 (20), Stats., that is used to treat or manage a psychiatric symptom or challenging behavior". On 01/05/2024, Surveyor reviewed Resident 4's record. S/he was admitted 01/03/2022. Diagnoses included anxiety disorder, unspecified, vascular dementia, and visual hallucinations. Physician orders included risperidone 0.25 MG 1 tablet once daily as needed for anxiety (start date 12/06/2023). Medication Administration Record MAR dated 12/01/2023-01/04/2024: Staff documented administration of PRN risperidone on the following dates: 12/09/2023 at 4:49 PM, 12/14/2023 at 9:31 PM, 12/19/2023 at 1:41 PM and on 12/21/2023 at 4:59 PM, staff coded "9" (other see nurses notes). Progress notes dated 12/06/2023-01/06/2023: There were no progress notes dated 12/09/2023, 12/14/2023, 12/19/2023 or 12/21/2023. ISP dated 08/25/2023 did not address prn risperidone including rationale for use and detailed description of the behaviors indicating need for it. On 01/05/2024 at 3:10 PM, Surveyors discussed concern of Resident 4's ISP not addressing prn risperidone with Wellness Director B, Executive Director F, Assistant Executive Director G, and Resident Care Coordinator H. Wellness Director B stated Resident 4 was readmitted from the hospital with new orders for the medication and staff called him/her prior to administering the	{N 408}		

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{N 408}	Continued From page 5 medication.	{N 408}		
N 441	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure employees followed hand washing procedures according to Centers for Disease Control and Prevention (CDC) standards. Med Tech I did not wash or sanitize hands between each resident during medication administration. This is a repeat violation. See Statement of Deficiency XXL911, dated 06/16/2022. Findings include: In October 2002, the CDC published the "Guideline for Hand Hygiene in Healthcare Settings." This guideline sets the standard for caregivers regarding glove use and hand washing to prevent the spread of infections. The CDC has recommended that caregivers wash their hands before having direct contact with residents, after contact with a resident's intact skin, after contact with body fluids or excretions, if moving from a contaminated-body site to a clean-body site during cares, after contact with inanimate objects and after removing gloves. On 01/05/2024 from 11:53 AM to 12:05 PM, Surveyor observed Med Tech I administer medications. The medication cart was stationed	N 441		

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N 441	Continued From page 6	N 441		

in the medication room which was kept locked. Med Tech I unlocked the medication room door using the touch key pad each time s/he entered the medication room during the medication administration.

On 01/05/2024 Surveyor observed the following: At 11:55 AM, Med Tech I sanitized his/her hands then administered medication to Resident 5. Med Tech I returned to the medication room and signed out Resident 5's medication on the lap top.

At 11:57 AM, Med Tech I prepped Resident 6's medication and retrieved applesauce from the kitchenette refrigerator. Med Tech I administered Resident 6's medications in the Great Room, then pushed Resident 6 in his/her wheelchair to the dining room. Med Tech I returned to the medication cart and signed out Resident 6's mediations on the lap top.

At 12:02 PM, Med Tech I prepped Resident 7's medication, administered the medication to Resident 7 in his/her room (touching the Resident 7's door knob twice), returned to the medication cart and signed out Resident 7's medication on the lap top.

At 12:05 PM, Med Tech I prepped Resident 8's medication.

On 01/05/2024 from 11:57 AM to 12:05 PM, Med Tech I did not wear gloves, sanitize or wash his/her hands during medication administration.

On 01/05/2024 at 12:08 PM, Surveyor interviewed Med Tech I who stated s/he did not wash or sanitize his/her hands because the bottle of hand sanitizer on the cart was almost empty. Med Tech I showed Surveyor the bottle of hand

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N 441	Continued From page 7 sanitizer which contained approximately ¼" of hand sanitizer. Med Tech I stated the hand sanitizer dispenser on the wall in the medication room was empty. Med Tech I stated s/he did not have access to more hand sanitizer and needed to request it from maintenance. On 01/05/2024 at 1:14 PM, Surveyor interviewed Wellness Director B who stated the expectation was that staff sanitized hands between resident med passes up to 3 times then wash their hands. On 01/05/2024 at 3:10 PM, Surveyors discussed concern of Med Tech I not washing or sanitizing his/her hands between each medication pass with Wellness Director B, Executive Director F, Assistant Executive Director G, and Resident Care Coordinator H. Assistant Executive Director G stated staff had access to backstock of gloves and hand sanitizer and they would re-educate staff.	N 441		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the facility was clean and free from odors. This is a repeat violation. See Statement Of Deficiency (SOD) #1KI812, dated 11/25/2023, SOD #1KI813, dated 03/18/2021 Findings include:	N 489		

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N 489	Continued From page 8	N 489		

The facility is licensed to serve up to 42 residents in the client groups of advanced age and irreversible dementia.
This provider is divided into two units. Unit A is downstairs and referred to as 'Clarebridge' and Unit B is upstairs and referred to as 'Crossings'.

On 01/05/2024 at 10:30 AM, Surveyor toured the physical environment of the facility with Assistant Executive Director G and observed the following:

Unit A- Clarebridge:
In the hallway near the conference room on the Clarebridge Unit, Surveyor observed a strong odor that permeated throughout the hallway into open resident rooms, and into the activity room. The odor was consistent with the smell of urine.

In room A9 there was a strong odor present consistent with the smell of urine and brown matter observed on the back of the sink. The toilet was also observed to be coated with feces and calcium deposits inside of the bowl and on the upper toilet seat lid. Surveyor asked Assistant Executive Director G if the facility employed a full-time housekeeper. Assistant Executive Director G replied that they did, but the housekeeper was currently on vacation.

In the kitchen of Clarebridge Surveyor observed a heavy accumulation of food debris, wrappers, water damaged sticky rodent and bug traps, and dirt covering the floor with the heaviest accumulation observed behind the serving tables. The steam tables in the kitchen were a fourth of the way full of standing water that was cloudy and full of coagulated globules of food. In the kitchenette refrigerator, that is accessible to residents, Surveyor observed two partially wrapped sandwiches that were not dated.

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Surveyor picked up one of the sandwiches and noted that the bread was very hard, and the meat was dried and discolored. The drawers and shelves of the refrigerator were spackled with an accumulation of crumbs and spills of red liquid. Assistant Executive Director G stated food is prepared at the sister facility next door, then brought over and put into the steam tables in this kitchen and served to residents and that sometimes staff will put their food into the refrigerators in the kitchenette.

Unit B- Crossings:
In room B3 Surveyor immediately noted a very strong odor as soon as the door to the room was opened by Assistant Executive Director G. Surveyor asked Assistant Executive Director G if anyone was currently living in the room. Assistant Executive Director G said, "No, but we set this room up for someone to move in this month." Surveyor then noticed an adult incontinence product soiled with urine and feces, on the floor under the bathroom sink in the unoccupied room. Assistant Executive Director G immediately found a garbage bag and wrapped the soiled undergarment up in it and stated that a resident must have wandered into the unoccupied room and disrobed.

In the kitchen on the Crossings unit Surveyor observed a heavy accumulation of food, dirt, and pest traps on the floor and behind the serving tables. Observed in the steam tables was water that was full of coagulated food globules. Assistant Executive Director G stated food is prepared at the sister facility next door, then brought over and put into the steam tables in this kitchen and served to residents.

On 01/05/2024 at 2:50 PM, Surveyor conducted

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N 489	Continued From page 10 an exit interview and shared findings. Assistant Executive Director G stated that the facility used to hire a contracted cleaning company to assist in cleaning the facility but was transitioning away from that. Surveyor asked if the facility had a plan for housekeeping coverage while the main housekeeper was on vacation. Assistant Executive Director G stated they did not have a plan but were trying to do a little here and there.	N 489		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the facility's heating system was inspected at least once every 3 years. Findings include: On 01/05/2024, at approximately 2:30 PM, Assistant Executive Director G provided Surveyor with a packet containing facility life safety	N 504		

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N 504	Continued From page 11 documents. Surveyor reviewed the packet of documents and was unable to locate documentation of any furnace inspection that was completed within the last 3 years. Surveyor asked Assistant Executive Director G if they had any furnace inspection completed by a heating contractor or local utility company. Assistant Executive Director G stated they would check but they didn't think they did. On 01/05/2024 at 2:50 PM, Surveyor interviewed Assistant Executive Director G about the missing furnace inspection. Assistant Executive Director G stated, "I was honestly unaware that I had to hire this service out. I thought I could just take a look at the furnace myself." Surveyor asked Assistant Executive Director G if s/he was a heating contractor or associated with a local utility company. Assistant Executive Director G stated, "No."	N 504		