STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017059	A. BUILDING: _____ B. WING _____	C 10/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE SENIOR LIVING LINCOLN CBRF	314 E LINCOLN AVE TOMAHAWK, WI 54487

(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 10/05/2023, Surveyor conducted 2 complaint investigations and an abbreviated survey. Information was reviewed through 10/11/2023. Six deficiencies were identified. Both complaints were unsubstantiated. Census: 14	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 interview and record review, the provider did not ensure each staff member had a complete background check at the time of hire. This was discovered for 1 of 3 sampled staff members. The provider did not have the Department of Justice (DOJ) disposition record of arrests,	N 219		

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

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N 219	Continued From page 1 charges, and convictions for Assistant Health Coordinator (AHC) B. The provider did not have the Integrated Background Information System (IBIS) letter of abuse findings and licensing from the Department of Health (DHS) for AHC B. Findings include: On 10/05/2023 at 1:58 PM, Surveyor requested Director A provide background checks for Staff E, AHC B, and Staff F. At 3:30 PM, Director A stated that the information was still being collected and would send the information in an email. On 10/06/2023 at 10:24 AM, the information was sent to Surveyor via email. Missing in the information was the DOJ report and the IBIS letter for AHC B. AHC B was hired on 06/04/2023. On 10/10/2023 at 1:47 PM, Director A sent an email to Surveyor stating the following: "Items for [AHC B] - I am uncertain if during [his/her] onboarding, certain things did not get filed where they should have but we are correcting it now ... unable to locate the DOJ print out, ran new one, see attached." Attached was a DOJ report and IBIS letter. Both were dated 10/10/2023.	N 219		
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	N 220		

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N 220	Continued From page 2 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 screening documentation for verification purposes. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure each staff member had documentation of being screened for communicable disease including tuberculosis (TB) within 90 days of being hired. This was discovered for 1 of 3 sampled staff members. Findings include: On 10/05/2023 at 1:58 PM, Surveyor requested Director A provide a health screen for communicable diseases for Staff E, Assistant Health Coordinator (AHC) B, and Staff F. At 3:30 PM, Director A stated the information was still being collected and would be sent in an email. On 10/06/2023 at 10:24 AM, the information was sent to Surveyor via email. Missing in the information was the TB test and other documentation of communicable diseases for AHC B. AHC B was hired on 06/04/2023. On 10/10/2023 at 1:47 PM, Director A sent an email to Surveyor stating the following: "Items for [AHC B] - I am uncertain if during [his/her] onboarding, certain things did not get filed where they should have but we are correcting it now as some of [his/her] initial training was in another building only because that is where the person training [his/her] was located so things may have gotten missed or misplaced in the shuffle...TB test - there was a note in	N 220		

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N 220	Continued From page 3 [his/her] file that we were out of supplies, they were on order and [s/he] should have been tested as soon as it arrived, that was over looked. They did it today..."	N 220		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure that each staff member had all of the department approved training. This	N 239		

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N 239	Continued From page 4 was discovered for 1 of 3 sampled staff members. Assistant Health Coordinator (AHC) B did not have training in fire safety within 90 days after starting employment. Findings include: On 10/05/2023, Surveyor reviewed the files of Staff E, AHC B, and Staff F to verify compliance with department approved training requirements. AHC B is a Licensed Practical Nurse (LPN). AHC B is not exempt from fire safety training. On 10/05/2023 at 1:58 PM, Surveyor requested Administrator A provide evidence of Fire Safety training for Staff E, AHC B, and Staff F. At 3:30 PM, Administrator A stated that the information was still being collected and would s/he would send the information in an email. On 10/06/2023 at 10:24 AM, the information was sent to Surveyor via email. AHC B had not completed Fire Safety training. AHC B was hired on 06/04/2023. On 10/10/2023 at 1:47 PM, Director A sent an email to Surveyor stating the following: "Items for [AHC B] - I am uncertain if during [his/her] onboarding, certain things did not get filed where they should have but we are correcting it now as some of [his/her] initial training was in another building only because that is where the person training [him/her] was located so things may have gotten missed or misplaced in the shuffle... Fire safety for some reason did not populate for [him/her] in [his/her] trainings; it was assigned to [him/her] today and [s/he] is working on it right now.	N 239		
N 491	83.44(2)(c) Interior floors, walls and ceilings.	N 491		

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N 491	Continued From page 5 Every interior floor, wall and ceiling shall be clean and in good repair. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the floor in the kitchen was in good repair and clean. There were several broken tiles and holes in the kitchen floor. The disrepair and uncleanliness of the floor in the kitchen had the potential to affect all of the residents. Findings include: On 10/05/2023 at 11:07 AM, Surveyor observed the condition of the kitchen floor. The floor was composed of 12-inch square individual tiles. The tiles had peeled off under the dish draining area in both corners. At least 4 tiles were missing and 1 tile in the corner of the room had peeled away and warped to the point it was barely glued to the underlayment. Surveyor observed the tiles under one of the refrigerators was also beginning to lift and warp along the seams. The kitchen had 2 drainage holes in the floor and the 4 tiles around each drain were broken, with the soiled underlayment showing. The residue appeared to be a combination of dirt and old glue. In addition, Surveyor counted approximately 22 other tiles broken in the dish room and main kitchen area with the dirt-filled underlayment exposed. At 11:15 AM, Surveyor interviewed Culinary Coordinator (CC) C. CC C stated Maintenance Person D was aware of the condition of the floor. CC C told Surveyor that replacing the floor had been talked about but that was all s/he knew. CC C stated the tiled floor was not the best option when the kitchen was built and a seamless floor may have been better.	N 491		

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N 491	Continued From page 6 At 2:55 PM, Surveyor interviewed Director A. Director A stated the kitchen floor had been talked about but there was nothing in the budget for repair or replacement of the flooring in the kitchen.	N 491		
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. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure fire drills were conducted at least quarterly, with one taking place that simulated the conditions during the residents' usual hours of sleep. This had the potential to affect all the residents. Findings include:	N 525		

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N 525	Continued From page 7 On 10/05/2023 at 8:45 AM, Surveyor interviewed Director A and requested the documentation of past fire drills back to January of 2021. Director A stated that Licensed Practical Nurse (LPN) G would have that information. At 11:50 AM, Surveyor interviewed LPN G. LPN G indicated the drills for June and July of this year would be coming in a fax in about an hour. At 12:55 PM, Surveyor interviewed LPN G. LPN G stated s/he was still looking for the fire and evacuation drills. At 2:55 PM. Surveyor interviewed Director A. Director A stated no fire drills were found and stated s/he was taking full responsibility as staff were unable to find any drills.	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 interview and record review, the provider did not ensure emergency evacuation drills were conducted twice a year. This had the potential to affect all the residents. Findings include: On 10/05/2023 at 8:45 AM, Surveyor interviewed Director A and requested the documentation of past evacuation drills back to January of 2021. Director A stated that Licensed Practical Nurse (LPN) G would have that information as s/he had a binder of information for the state. At 12:55 PM, Surveyor interviewed LPN G. LPN G stated s/he was still working on putting the binder together. At 2:55 PM. Surveyor interviewed Director A.	N 526		

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N 526	Continued From page 8 Director A stated no evacuation drills were found.	N 526		