STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018628	A. BUILDING: _____ B. WING _____	C 11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABRIDGE CARE COTTAGE OF KEWAUNEE	1100 BAUMEISTER DR KEWAUNEE, WI 54216

(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 11/01/2023, Surveyor conducted a standard survey and 2 complaint investigations at Abridge Care Cottage in Kewaunee. Two (2) of 2 complaints were substantiated. As a result of the survey, 3 deficiencies will be issued. Census: 13	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 employed 1 of 3 (Former Caregiver B) caregivers reviewed who had a governmental finding of misconduct and had not been approved under the department's rehabilitation process. This had the potential to affect all 13 residents.	N 219		

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
	0018628	A. BUILDING: _____ B. WING _____	C 11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABRIDGE CARE COTTAGE OF KEWAUNEE	1100 BAUMEISTER DR KEWAUNEE, WI 54216

(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 219	Continued From page 1 Findings Include: On 08/01/2023, the department received a complaint regarding allegations of caregiver abuse and misappropriation and that caregivers were working at the facility who were listed on the caregiver misconduct registry. On 11/01/2023, Surveyor conducted an onsite visit to the facility. Surveyor requested a sample of employee background checks, including the employee record of Former Caregiver B. Former Caregiver B was hired on 08/10/2022. An Integrated Background Information Systems (IBIS) check completed on 08/19/2022 indicated Former Caregiver B had a misappropriation finding on 09/04/2018. Additionally, the IBIS check indicated Former Caregiver B had "no rehabilitation review findings." On 11/01/2023 at 11:55 A.M., Surveyor interviewed Vice President of Operations (VPO) A. VPO A indicated s/he provided a self report to the department regarding the allegations of misappropriation and resident rights violations involving Former Caregiver B. VPO A stated law enforcement was also involved in the investigation. VPO A indicated while conducting the investigation into the allegations of misappropriation and resident rights violations, VPO A reviewed the background checks for Former Caregiver B. During the review, VPO A discovered the findings on the caregiver registry. VPO A stated upon hearing of the allegations, Former Caregiver B was notified s/he was suspended until the investigation was concluded. VPO A stated Former Caregiver B quit upon hearing about the suspension. VPO A stated if Former Caregiver B had not quit, s/he would have	N 219		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018628	A. BUILDING: _____ B. WING _____	C 11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABRIDGE CARE COTTAGE OF KEWAUNEE	1100 BAUMEISTER DR KEWAUNEE, WI 54216

(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 219	Continued From page 2 been terminated after discovering the findings on the background checks. VPO A stated the original background check review was done by someone no longer employed with the company and the company now has a new system for conducting background checks. It is an automated system, where the employee fills out the background check information, this is submitted to the state. The results are sent to human resources and VPO A for review. VPO A stated they have instituted this new background check system in April and have not had any problems.	N 219		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by: Based on record review and interview, the provider did not document in the resident's record any error in the administration of prescription medication for 1 of 2 (Resident 1) residents reviewed.	N 410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018628	A. BUILDING: _____ B. WING _____	C 11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABRIDGE CARE COTTAGE OF KEWAUNEE	1100 BAUMEISTER DR KEWAUNEE, WI 54216

(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 410	Continued From page 3 On 09/05/2023, Resident 1 was prescribed lorazepam 0.5mg (milligrams) every 4 hours PRN (as needed). On 09/11/2023, Resident 1 was given a dose of lorazepam at 5:00 P.M. and 6:23 P.M. Resident 1's record did not contain documentation this error was documented and investigated. Findings Include: On 09/20/2023, the department received a complaint regarding medications. On 11/01/2023, Surveyor conducted an onsite visit to the facility. A sample of residents was selected, including the record of Resident 1. A physician's note faxed to the facility dated 09/19/2023 stated, "In reviewing [Resident 1's] med pass history, on 09/11/2023, [Resident 1] was given Lorazepam at 5:00 pm and again at 6:23 pm. If you notice on the attached med list that the directions are to be given every 4 hours as needed. So, if it was given at 5:00 pm, it should've not been given again until 9:00 pm..." On 08/11/2023, Resident 1's physician orders Lorazepam 0.5mg twice a day PRN. On 08/14/2023, Resident 1's physician orders Lorazepam 0.5mg three times a day PRN. On 09/05/2023, Resident 1's physician orders Lorazepam 0.5mg every 4 hours PRN. Resident 1's Med Pass History from 09/01/2023 through 09/30/2023 indicates the following: - on 09/11/2023 Resident 1 was administered lorazepam 0.5mg at 5:00pm	N 410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018628	A. BUILDING: _____ B. WING _____	C 11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABRIDGE CARE COTTAGE OF KEWAUNEE	1100 BAUMEISTER DR KEWAUNEE, WI 54216

(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 410	Continued From page 4 - on 09/11/2023 Resident 1 was administered lorazepam 0.5mg at 6:23pm On 11/01/2023 at 1:15 P.M., Surveyor interviewed Vice President of Operations (VPO) A regarding the physician's note on 09/19/2023. VPO A stated, "This is the first I am hearing about the medication error." VPO A verified they did not have documentation of the medication error or an investigation into the error. VPO A stated the Residence Manager that would have received the physician's note no longer works at the facility.	N 410		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018628	A. BUILDING: _____ B. WING _____	C 11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABRIDGE CARE COTTAGE OF KEWAUNEE	1100 BAUMEISTER DR KEWAUNEE, WI 54216

(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 431	Continued From page 5 changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not monitor the health and make arrangements for physical health services including, not monitoring the food intake and report significant deviations from normal food intake patterns for 1 of 2 (Resident 1) residents reviewed. Resident 1 was noted to have a decreased appetite and had an 8lb (pound) weight loss over one month. This was not reported to the physician by the facility. The physician ordered Resident 1 to start a protein supplement drink. The facility did not follow through on the order. Findings Include: On 09/20/2023, the department received a complaint regarding care and treatment. On 11/01/2023, Surveyor conducted an onsite visit to the facility. A sample of residents was selected, including the record of Resident 1. Resident 1 was admitted to the facility on 08/07/2023 with diagnoses to include hypercholesterolemia, hyperlipidemia, hypertension, left thalamic infarction and vascular	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018628	A. BUILDING: _____ B. WING _____	C 11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABRIDGE CARE COTTAGE OF KEWAUNEE	1100 BAUMEISTER DR KEWAUNEE, WI 54216

(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 431	Continued From page 6	N 431		

dementia. Resident 1's most recent ISP (individualized service plan) dated 08/07/2023 states staff are to obtain Resident 1's weight on a monthly basis and to notify leadership with weight loss/gain of 5 lbs with concerns reported to physician.

Surveyor requested Resident 1's weights since time of admission. The following was noted:
-08/11/2023 weight was 179.9 lbs
-09/13/2023 weight was 177.8 lbs
-10/05/2023 weight was 169.4 lbs

A physician's note faxed to the facility on 09/19/2023 states, "In talking with [Resident 1's Power of Attorney]...[Resident 1] has not been eating very well and has lost a lot of weight...for additional nutrition, [physician] would like [Resident 1] to have Ensure Boost midmorning and midafternoon. As per our discussion, please let me know if family will need to provide or if [Resident 1's] insurance will cover."

Surveyor reviewed Resident 1's MAR (medication administration record) for September and October 2023 and did not find any information regarding Resident 1 receiving Ensure Boost.

On 11/01/2023 at 1:15 P.M., Surveyor interviewed VPO (Vice President of Operations) A regarding the physician's note on 09/19/2023. VPO A stated, "It's the first I'm hearing about the order for Boost." VPO A verified Resident 1 had not been receiving Ensure Boost. VPO A stated they would be notifying the physician this afternoon of the weight loss and to get the actual order for the Ensure Boost. VPO A stated the Residence Manager that would have received the physician's note no longer works at the facility.