STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019329	A. BUILDING: _____ B. WING _____	R-C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT CEDAR RIDGE IV	4932 ALDERSON ST SCHOFIELD, WI 54476

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{N 000}	Initial Comments On 11/09/2023, Surveyor conducted a probationary standard survey, 2 complaint investigations, and a verification visit, at Traditions of Cedar Ridge IV. Information was reviewed through 11/30/2023. Eight deficiencies were identified. Both complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit is being assessed. Census: 11	{N 000}		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure an investigation was completed for an injury of unknown source. Resident 1 was found to have bruising on 2 occasions. The facility had no investigation into the possible cause. Findings include: On 10/16/2023, the department received a complaint alleging there was no investigations	N 161		

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

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N 161	Continued From page 1 into an injury of unknown source. On 11/09/2023 at 11:53, Surveyor interviewed Caregiver E. Caregiver E was aware of the caregiver's responsibility to report bruising right away to the house manager. Staff are to fill out a "Resident Concern Form" to start the process of reporting. A blank copy was shared with Surveyor. On 11/09/2023 at approximately 1:00 PM, Surveyor reviewed the record for Resident 1. There were 2 documented incidences of injuries of unknown source: 1. In the "Resident Safety Checks" on 06/01/2023, staff recorded "new bruising on [his/her] back and left wrist area. 15-[minute] checks started." There was no other entry regarding this injury of unknown origin. 2. In the "Nurse notes" on 06/17/2023, staff recorded that upon completing bedtime cares, the staff noted Resident 1 "is bruised from knee to ankle and seems to be causing pain." There is no other entry regarding this injury of unknown source. On 11/09/2023 at 2:25 PM, Surveyor interviewed Director A. Surveyor was given a blank "Incident Report" as this outlined what the investigation should be. Director A stated that no investigation into these injuries of unknown origin could be found. Director A stated the provider's procedure is to immediately start an investigation and complete the incident report and investigation. Director A indicated that Former Director (FD) D was also in charge of this facility and a sister facility in Weston. Director A indicated that the missing documentation may be unattainable as	N 161		

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N 161	Continued From page 2 FD D may have put several bits of information in a personal computer that was not available. Director A also stated the information may be in the stack of papers to be filed and Director A would send it if it were found. The provider sent information via emails on 11/03/2023 and 11/21/2023. The investigations were not received.	N 161		
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 procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each staff member had evidence of 15 hours of continuing education. This education is to include, at a minimum, standard precautions; client group related education; medications; resident rights; prevention and reporting of abuse, neglect, and misappropriation; and fire safety and emergency procedures, including first aid. The provider had no records of Caregiver F's continuing education	N 277		

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N 277	Continued From page 3 hours for the year 2022. This was discovered for 1 of 1 sampled staff that had worked in 2022. Findings include: On 11/09/2023 at 12:30 PM, Surveyor reviewed the training records for Caregiver F. Caregiver F's date of hire was 05/21/2021. Caregiver F had orientation training in 2021, and recorded training in 2023, but there was no training recorded in 2022. At 11/13/2023 at 9:46 AM, Surveyor interviewed Director A. Director A stated the training would have been the responsibility of the former management company and their poor performance was the reason the current owner "got rid of them." Director A stated that if the paperwork could be found, the provider would send it to Surveyor. The education for Caregiver F in 2022 was not included in information sent to Surveyor on 11/09/2023 and 11/21/2023.	N 277		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening	N 302		

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N 302	Continued From page 4 documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident was screened for a communicable disease by a medical professional within 90 days before or 7 days after their admission. This was discovered for 1 of 2 sampled residents. Resident 1 did not have documentation of a health screen. Findings include: On 11/09/2023 at approximately 1:00 PM, Surveyor reviewed Resident 1's information in his/her binder. There was no health screen by a medical professional prior to Resident 1's admission on 03/10/2023. At 2:25 PM, Surveyor interviewed Director A. Director A stated that the health screen could be in some of the filings that had not been done yet and if found s/he would send it to Surveyor. The health screen was not in the information submitted to Surveyor via email on 11/13/2023 and 11/21/2023.	N 302		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan	N 385		

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N 385	Continued From page 5 under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident had a written temporary service plan completed at the time of admission. The temporary service plan would outline for staff the resident's individual and immediate needs. This was discovered for 1 of 2 sampled resident records. Resident 1 did not have a temporary service plan on file. Findings include: On 11/09/2023 at approximately 1:00 PM, Surveyor reviewed Resident 1's information in his/her binder. There was no temporary care plan at the time of Resident 1's admission on 3/10/2023. At 2:25 PM, Surveyor interviewed Director A. Director A stated the temporary service plan might be in some filing that had not been done yet and if found s/he would send it to Surveyor. The temporary service plan was not in information submitted to Surveyor via email on 11/13/2023 and 11/21/2023.	N 385		
N 392	83.35(4) Resident satisfaction evaluation. Satisfaction evaluation. At least annually, the CBRF shall provide the resident and the resident ' s legal representative the opportunity to complete an evaluation of the resident ' s level of satisfaction with the CBRF ' s services. The evaluation shall be completed on either a department form or a form developed by the CBRF and approved by the department.	N 392		

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N 392	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident and their legal decision maker had the opportunity to complete a department approved evaluation of the resident's satisfaction of the provider's services. Findings include: On 11/09/2023 at approximately 1:00 PM, Surveyor reviewed the service binder for Resident 1's satisfaction surveys and was unable to find any. Resident 1 had been a resident at the facility since March of 2021. At 2:25 PM, Surveyor interviewed Director A. Director A stated the resident's annual satisfaction surveys might possibly be in some paperwork that had yet to be filed in the residents' records and s/he would email the evaluations to Surveyor if found. The satisfaction surveys were not included in the information emailed to Surveyor via email on 11/13/2023 and 11/21/2023.	N 392		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s	N 404		

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N 404	Continued From page 7 medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have evidence that a medical professional such as a physician, physician extender, pharmacist or registered nurse conducted an on-site review at least annually of the provider's medication administration and medication storage systems. Findings include: On 11/09/2023 at 9:35 AM, Surveyor requested of Director A, the annual medication review. At 2:25 PM, Surveyor interviewed Director A. Director A stated s/he was unable to locate the review and indicated it may be amongst a stack of filing in the office. Director A stated that the review would be sent to Surveyor if it was located. The review was not in information sent via email to Surveyor on 11/13/2023 and 11/22/2023.	N 404		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a	N 407		

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N 407	Continued From page 8 resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident that received a scheduled psychotropic medication was reviewed at least quarterly by a medical professional for the desired response and possible side effects. The review was to be documented and placed in the resident's record. This was discovered for 1 of 2 residents receiving this type of medication. Findings include: On 10/16/2023. The department received a complaint about a resident-to-resident altercation in which the aggressor's psychotropic medications were not effective to prevent the altercation. On 11/09/20232, at approximately 1:30 PM, Surveyor reviewed the medication review for Resident 2. The only record of quarterly reviews was dated for year 2022 and was unsigned by a medical professional. Resident 2 received olanzapine 10 mg at bedtime for his/her Bi-Polar condition. There was no record of the quarterly reviews for 2023.	N 407		

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N 407	Continued From page 9 At 2:25 PM, Surveyor interviewed Director A. Director A indicated that Former Director (FD) D was also in charge of this facility and a sister facility in Weston. Director A indicated that the missing documentation may be unattainable as FD D may have put information in a personal computer that is not available. Director A stated a continued search would be done and any reviews found would be sent to Surveyor. The provider sent a series of emails on 11/13/2023 and 11/21/2023. The quarterly reviews were not received.	N 407		
N 440	83.39(2) Infection control program policies/training The infection control program shall include written policies and training for employees. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have a written infection control policy and procedure that reflected current standards of practice for respiratory infections and severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Findings include: On 08/27/2023, the department received a complaint that the provider did not know how to handle staff members with COVID. On 11/09/2023 at 9:35 AM, Surveyor asked Director A for a copy of the provider's infection control policies and procedures related to COVID. At 11:50 AM, Surveyor was given an undated	N 440		

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copy of the policy by Director B. The policy was outdated as it still spoke about visitation at closed windows, not allowing deliveries, only sending residents to medical appointments as determined by the house managers, maintaining 6 feet apart, eating in their rooms or eating at the far ends of the tables, no large group activities, the use of cloth face masks, and reusing single use paper masks. This procedure was not consistent with current standards of practice that prohibit the use of cloth masks, and isolating those residents who were ill and not everyone in the long-term care environment. There were no updated procedures for how to prevent the spread of COVID in a non-pandemic world. The procedure began, "Cedar Ridge has a no visitor policy due to the Covid - 19 [sic] pandemic as posted on the front door..."

At 2:25 PM, Surveyor interviewed Director A. Director A stated s/he, Director B and Director C would continue to look for an updated policy and submit it to Surveyor if found. The current standard of practice for infection control of SARS-CoV-2 is found at https://www.cdc.gov/longtermcare/index.html. The information includes clinical staff information, resident safety, prevention tools, training, and health department resources. Directions to this Centers for Disease Control and Prevention site was shared with Director A and Director B.

No further information on infection control was received in the provider's emails of 11/13/2023 and 11/21/2023.