STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012234	A. BUILDING: _____ B. WING _____	C 07/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DI LANA HOUSE	W274 S4025 TIMBER TRL WAUKESHA, WI 53189

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N 000	Initial Comments On 07/12/2023, with information gathered through 07/24/2023, Surveyor conducted a standard licensure survey and complaint investigation at Di Lana House. Eleven deficiencies were identified. Two of the 11 deficiencies were repeat violations (see Statement of Deficiency (SOD) N7U511, SOD N7U512, SOD N7U513, and SOD N7U514). Complaint was unsubstantiated. Census: 7	N 000		
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 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 record review and interview, the provider did not ensure 2 of 3 employee records (Resident Aide C and Resident Aide D) reviewed had been screened for clinically apparent communicable disease, including tuberculosis	N 220		

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

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N 220	Continued From page 1 (TB), by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse within 90 days before the start of employment. Findings include: On 07/11/2023, at approximately 11:30 AM, Surveyor reviewed Resident Aide C's and Resident Aide D's employment file. Resident Aide C has a hire date of 02/02/2022. Resident Aide C's employee record contained a negative TB test result, dated 03/15/2022. Resident Aide C's TB test was not completed within 90 days before the start of employment. Resident Aide D has a hire date of 04/17/2023. Resident Aide D's record did not contain a TB test or a communicable disease screen. Licensee A and Administrator B reviewed the record and stated they would forward that documentation to Surveyor. On 07/12/2023, Surveyor reviewed Resident Aide D's TB test result which was dated 07/12/2023. Resident Aide D's TB test was not completed within 90 days before the start of employment and his/her record did not have a communicable disease screen.	N 220		
N 284	83.26(2) Orientation, continuing education documented Employee orientation and hours of continuing education shall be documented in the employee ' s file. This Rule is not met as evidenced by: Based on record review and interview, the	N 284		

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N 284	Continued From page 2 provider did not ensure each employee's required continuing education (CE) training was documented for 1 of 1 employee reviewed. Resident Aide E's record did not include documentation of 2021's and 2022's CE training. Findings include: On 07/12/2023, Surveyor requested the continuing education training records for Resident Aide E who was hired on 02/05/2020. Resident Aide E's training record contained a certificate that documented Resident Aide E received 23 hours of continuing education on 05/24/2021 in resident rights, client group specific, managing challenging behaviors, provisions of personal care and dietary. Resident Aide E's training record contained a certificate that documented Resident Aide E received 23 hours of continuing education on 05/29/2022 in resident rights, client group specific, managing challenging behaviors, provisions of personal care and dietary. On 07/24/2023, at approximately 1:05 PM, Surveyor requested what specific training courses Resident Aide E had completed on 05/24/2021 and 05/29/2022 to meet the requirements that 23 hours of training had been received in resident rights, client group specific, managing challenging behaviors, provisions of personal care and dietary. As of 5:30 PM, Surveyor did not receive any additional documentation.	N 284		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan	N 386		

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N 386	Continued From page 3 Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 residents had a completed comprehensive Individual Service Plan (ISP) within 30 days of admission, which included the resident's needs and desired outcomes; and did not establish measurable goals with specific time limits for attainment. Resident 4's record did not contain a comprehensive ISP. Findings include: On 07/12/2023, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the facility, 02/24/2022. Resident 4's record contained a managed care organization member centered plan, dated 01/01/2022, which was created when Resident 4	N 386		

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N 386	Continued From page 4 resided at another community-based residential facility (CBRF). The member centered plan documented: "CBRF assist with redirection SIB (self-injurious) behaviors when they come up." "CBRF staff to cue the member to complete grooming tasks." "CBRF staff to assist the member with bathing tasks." "CBRF staff to assist the member with dressing and application of tubi grips" "CBRF staff to provide cueing for the member with mobility." "CBRF staff to assist the member with meal prep/grocery shopping" "CBRF staff to assist the member with laundry and chores." "CBRF staff to assist with overnight cares and supervision." "CBRF staff to assist with budgeting." "Member will remain complaint [sic: compliant] with taking [his/her] medications. Member is unable to administer or manage [his/her] own medications due to [his/her] impaired cognition and mental health." Resident 4's record did not contain a comprehensive ISP. On 07/11/2023, at approximately 12:30 PM, Surveyor interviewed Licensee A and Administrator B. Licensee A and Administrator B stated that the managed care organization member centered plan was utilized as Resident 4's ISP until his/her updated ISP, dated 04/06/2023.	N 386		
N 389	83.35(3)(d) Service plans updated annually or on changes	N 389		

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N 389	Continued From page 5 Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents (Resident 1 and Resident 3) reviewed Individual Service Plans (ISP) were reviewed annually as required. Findings include: On 07/12/2023, Surveyor reviewed Resident 1's and Resident 3's record. Resident 1 was admitted on 06/01/2010. Resident 1's record contained an ISP, dated 02/2022, which did not contain any signatures by Resident 1's Guardian H, managed care organization Care Manager I, or the provider. Resident 3 was admitted on 10/28/2016. Resident 3's record contained an ISP, dated 12/11/2020, and did not contain any signatures by Resident 3's Guardian F, managed care organization Care Manager G, or the provider.	N 389		

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N 389	Continued From page 6 On 07/11/2023, at approximately 12:30 PM, Surveyor interviewed Licensee A and Administrator B. Licensee A and Administrator B discussed amongst themselves that the signatures had not been obtained by Resident 1's and Resident 3's care team.	N 389		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that a Resident Satisfaction Survey was completed for all residents in 2021 and 2022. Findings include: On 07/11/2023, at approximately 11:30 AM, Surveyor requested the 2021 and 2022 Resident Satisfaction Survey that was sent out to the Resident 1, Resident 2, and Resident 3. Administrator A stated the surveys had not been made available to the residents or their representatives.	N 392		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate each resident ' s mental or physical capability to respond to a fire alarm at least annually or when	N 394		

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N 394	Continued From page 7 there is a change in the resident ' s mental or physical capability to respond to a fire alarm. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 resident records reviewed (Resident 1, Resident 3, Resident 4) were evaluated annually to determine their mental or physical capability to respond to a fire alarm. Findings include: The provider is licensed to care for a maximum of 8 residents from client groups emotionally disturbed / mental illness, advanced aged, developmentally disabled and irreversible dementia/Alzheimer's; the facility census was 7. On 07/11/2023, Surveyor reviewed Resident 1, Resident 3 and Resident 4's record. Resident 1 was admitted on 06/01/2010. Resident 1's evacuation assessment was dated 05/16/2014. Resident 3 was admitted on 10/28/2016. Resident 3's evacuation assessment was dated 10/29/2016. Resident 4 was admitted on 02/24/2022. Resident 4's evacuation assessment was dated 02/25/2022. On 07/11/2023, at approximately 12:30 PM, Surveyor asked Licensee A and Administrator B if Resident 1's, Resident 3's and Resident 4's annual evacuation assessments had been completed. Licensee A and Administrator B stated the annual assessments had not been completed.	N 394		

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N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not store food under sanitary conditions. Surveyor found food items in the refrigerator and freezer that were not properly sealed to avoid freezer burn and contamination; food packages stored in the dry food area were not sealed properly. This deficiency is being cited for a fifth time. See Statement of Deficiency (SOD) N7U511 dated 02/15/2018, SOD N7U512 dated 08/09/2018, SOD NU7513 dated 07/24/2019, and SOD NU7514 dated 05/26/2021. Findings include: On 07/12/2023, at approximately 11:00 AM,	N 452		

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N 452	Continued From page 9 Surveyor toured facility kitchen and observed the following: Refrigerator: A plate that contained 3 pancakes that were not sealed and dated An opened 1-pound package of bologna that was not sealed and dated An opened 9-pack of English muffins that were not sealed A stalk of celery that displayed black wilted leaves on 2 stalks that resembled spoilage Freezer: An opened bag of 50 pizza rolls which was not sealed An opened 19-ounce box of crunchy fish fillets which was not sealed An opened box of 10 breakfast links that was not sealed Pantry: An opened package of duplex sandwich crème cookies that were not sealed. Surveyor noted there was a sign on the refrigerator door that read, "All Food Is To Be Dated And Labeled When Put in Fridge Including Staff's Food." At approximately 1:00 PM, staff placed (2) 28-ounce boxes of frozen gravy & Salisbury steak into the kitchen sink and 2 bags of steamable broccoli florets; the packaging's read to 'keep frozen.' Administrator B stated the food was thawing for the evening meal. On 07/11/2023, at approximately 12:30 PM, Surveyor interviewed Licensee A and Administrator B. Licensee A and Administrator B	N 452		

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N 452	Continued From page 10 stated they would discuss the concern with staff, the importance of making sure food is adequately stored and dated. "Time/temperature control for safety (TCS) guidelines indicate food prepared in a food establishment and held longer than a 24 hour period shall be marked to indicate the date or day by which the food is to be consumed on the premises, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Refrigerated, RTE (ready-to-eat)/TCS food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed or discarded." (US Food and Drug Administration (FDA) Food Code, 2017, Section 3-501.17) "Ready-to-eat TCS food (foods that need time and temperature control for safety) can be stored for only seven days if it is held at 41 degrees Fahrenheit or lower. The count begins on the day the food was prepared or a commercial container was open. TCS foods includes milk and dairy products, eggs, meat (beef, pork, and lamb), poultry, fish, shellfish and crustaceans, baked potatoes, tofu or other soy protein, sprouts and sprout seeds, sliced melons, cut tomatoes, cut leafy greens, untreated garlic-and-oil mixtures, and cooked rice, beans, and vegetables." (ServSafe Coursebook, 7th edition, 2017, p. 1-7, p. 1-8, and p. 7-3).	N 452		
N 481	83.43(1) Environment safe, clean, and comfortable	N 481		

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N 481	Continued From page 11 Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a living environment that is safe, clean, comfortable, and homelike. This is a repeat deficiency. See Statement of Deficiency (SOD) NU7514, dated 05/06/2021. Findings include: On 07/11/2023, at approximately 10:30 AM, Surveyor toured facility and observed the following: Lower Level of Home: Surveyor walked down to the lower level of the home where Resident 1's and Resident 2's shared bedroom is located. Surveyor noted the lower level of the home had a smell that resembled a damp musty smell. Upon entrance to Resident 1's and Resident 2's bedroom, Surveyor observed the curtain rods to be bent and hanging loosely from the wall. The carpeting contained an approximately 1-inch-wide section across the entire room length that did not contain carpet material, just the carpet matting, and smaller sections throughout the room that only displayed the carpet matting. Resident Bathrooms Surveyor attempted to turn on the faucet to temp	N 481		

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N 481	Continued From page 12	N 481		

the water in the resident bathroom, located near Resident 4's room, but the sink did not have running water in the sink.
Resident bathroom vanity light fixture, located on lower level of home, contained 2 burnt out lightbulbs out of 3.

Kitchen Area:
- Four slice toaster was covered in a heavy layer of grease resulting in food particles and dust to collect
- Stove hood felt greasy to touch
- Undercabinet can opener that was covered in a brown platter substance and felt greasy to the touch
- Refrigerator interior, along door seal, displayed a black substance that could be wiped off which resembled mold
- Inside sink vanity contained a piece of linoleum that was covered in a brown substance that covered the entire vanity base which felt greasy to the touch
- White cabinetry throughout kitchen displayed brown and black markings around handles, possibly caused from opening and closing the cabinets with bare hands

Common Area:
- The brown leather sofa and loveseat displayed significant wearing giving the furniture the appearance of significant color distortion where one would sit, rest their head and arms.

On 07/11/2023, at approximately 1:00 PM, Surveyor toured the facility with Licensee A and Administrator B. Licensee A and Administrator B informed Surveyor that the water is turned off to some of the bathroom sinks, due to Resident 1 and Resident 2 playing in the water and at times had flooded the bathrooms. Licensee A and

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N 481	Continued From page 13 Administrator B stated they would look into getting a dehumidifier for the lower level of the home but there are concerns that Resident 1 will disassemble the device. Licensee A and Administrator B stated they would discuss the food concerns and the cleanliness concerns with staff.	N 481		
N 539	83.48(3)(b) Sensitivity testing performed Sensitivity testing shall be performed at intervals in accordance with NFPA 72. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the smoke and heat detection system had sensitivity testing for each device performed at intervals in accordance with NFPA (National Fire Alarm and Signaling Code) 72 requirements. Findings include: On 07/11/2023, Surveyor reviewed the facility life safety code documentation. There was no documentation found that the smoke and heat detection system had sensitivity testing in 2021 or 2022. On 07/11/2023, at approximately 12:30 PM, Surveyor asked Licensee A and Administrator B if there was documentation indicating sensitivity testing had been conducted in 2021 and 2022. Licensee A and Administrator B looked through the documentation and were unable to determine if the sensitivity testing had been completed. Administrator B stated s/he would contact the vendor and have them send over verification.	N 539		

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N 539	Continued From page 14 On 07/13/2023, Administrator B emailed Surveyor the following notation from the vendor: "We tested all the devices on the fire alarm side of the system, and everything worked properly. We tested all the smoke detectors, heat detectors, and pull stations." Surveyor noted this language was documented in the fire detection paper work that was reviewed by Licensee A and Administrator B on 07/11/2023 and did not specify if the sensitivity test had been performed.	N 539		
N 613	83.55(4)(a) Bath and toilet areas: privacy. Bath and toilet rooms shall have door locks to ensure privacy, except where the toilet, bath or shower room is accessed only from a resident room that is occupied by one person. All door locks shall be operable from both sides. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 2 bathroom doors had locks to ensure privacy. Findings include: On 07/11/2023, at approximately 1:00 PM, Surveyor toured the facility with Licensee A and Administrator B. Surveyor observed 2 of 2 bathrooms to be equipped with a lockable doorknob. Surveyor tested the door lock and found 1 of 2 bathroom door locks did not lock. Licensee A stated the bathroom door lock would be replaced. Cross Reference: N0639 DHS 83.59(2)(a)	N 613		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012234	A. BUILDING: _____ B. WING _____	C 07/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DI LANA HOUSE	W274 S4025 TIMBER TRL WAUKESHA, WI 53189

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N 613	Continued From page 15 One-Hand, One-Motion Door Operation	N 613		
N 639	83.59(2)(a) One-hand, one-motion door operation All doors shall have latching hardware to permit opening from the inside with a one-hand, one-motion operation without the use of a key or special tool. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all doors had latching hardware to permit opening the door from the inside with a one hand, one motion operation, without the use of a key or a special tool. Findings include: The provider is licensed to care for a maximum of 8 residents from client groups emotionally disturbed / mental illness, advanced aged, developmentally disabled, and irreversible dementia/Alzheimer's. On 07/11/2023, at approximately 1:00 PM, Surveyor toured the facility with Licensee A and Administrator B. Surveyor observed all resident bedroom doors could not be locked from the inside the resident's room with a one hand, one motion operation. Surveyor observed that the resident bedroom doors did not require a key or a device to open the door from the outside. Surveyor asked Licensee A and Administrator B why the resident bedrooms were not equipped with door handles that could be locked from the inside and opened with a key or a device from the outside. Licensee A and Administrator B stated the door handles would be replaced.	N 639		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 639	Continued From page 16 Cross Reference: N0613 DHS 83.55(4)(a) Bath and Toilet Areas: Privacy	N 639		