STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011302	A. BUILDING: _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM - KRISTY LANE	1038/1040 KRISTY LANE ONALASKA, WI 54650

(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
M 000	INITIAL COMMENTS On 10/16/2024, Surveyor conducted a standard licensure and self-report survey at REM Kristy Lane. Data collection continued through 10/31/2024. Three deficiencies were identified. Census: 2	M 000		
M 276	88.05(3)(a) HOME ENVIRONMENT An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the home was clean and well-maintained. Findings include: The provider is licensed to care for 4 residents in the client groups developmentally disabled and traumatic brain injury. On 10/16/2024, from approximately 11:00 AM to 2:30 PM, Surveyor observed the following: Laundry Room -A shelf above the washer and dryer contained a pile of crumpled up clothes. -Socks and single use dryer sheets were on the	M 276		

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

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M 276	Continued From page 1	M 276		

floor between the washer and dryer.
-Approximately 5 socks were scattered on the floor throughout the room along with multiple dryer sheets.

Resident 2's Bathroom (Lower Level of Home)

-A purple towel lying on the floor near the shower.
-A red rug in front of the sink had various white pieces of unknown debris along with what appeared to be a store receipt.
-Two articles of clothing lying on the floor.
-The sink had brown and black substances that appeared to be dried.
-The toilet had significant yellow and brown stains inside the bowl. There appeared to be a bowel movement sitting at the bottom of the bowl along with multiple areas of brown splatter marks.
-Plastic gloves lying on the floor near the toilet.
-Brown splatter marks on the floor near the garbage can.
-The toilet paper holder contained an empty toilet paper roll. The full roll of toilet paper was sitting on the sink.
-The inside floor of the bathtub had yellow and gray discoloration.

Hallway Outside of Resident 2's Bedroom (Lower Level of Home)

-Multiple small pieces of what appeared to be toilet paper on the floor.

Resident 2's Bedroom (Lower Level of Home)

-The room was cluttered and contained numerous articles of clothing scattered on the floor throughout the room.
-Plastic wrappers, pieces of paper, and multiple pieces of debris on the carpet.

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-Multiple black, round stains on the carpet.
-An empty plastic package labeled as peanut butter crackers at the base of one of the dressers. There was an intact cracker sitting outside of the package along with a cracker that was broken into many small pieces.
-There appeared to be other food debris on the carpet near a laundry basket.

Vacant Room Next to Resident 2's Bedroom (Lower Level of Home)

-The room contained an exit door to the outside. The room appeared to be used as a storage space.
-Clothing was scattered throughout the room on the floor. The clothing could pose as a fall risk if residents needed to utilize the door to exit the home in an emergency.
-Multiple recliners covered with clothing and multiple television sets.
-The closet doors had been removed and propped up against the wall near the closet.
-The main door to the room had two cracks in it approximately 8 inches from the door handle.

At approximately 12:20 PM, Surveyor toured the home with Program Director (PD) C. Surveyor brought PD C into Resident 2's bathroom and bedroom to discuss cleanliness. PD C stated s/he was not sure if Resident 2 preferred staff assistance with cleaning. PD C acknowledged Surveyor's concerns and stated it was something the provider could address during the next staff meeting. PD C stated staff could consider getting into a cleaning routine when Resident 2 was at work.

At approximately 1:50 PM, Surveyor interviewed Caregiver A. Caregiver A stated residents were

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M 276	Continued From page 3 responsible for cleaning. Caregiver A stated s/he tried to get Resident 2 to clean and had considered cleaning when Resident 2 was not home. Caregiver A stated staff could assist with cleaning the toilets as that required chemicals, but ultimately it was Resident 2's chore. Caregiver A stated s/he very seldom went down to the lower level of the home. Caregiver A stated s/he went down there one day to sweep the laundry room and shortly after it went right back to the way it was. At approximately 2:15 PM, Surveyor interviewed Caregiver E. Caregiver E stated it took a lot of redirection for Resident 2 to complete tasks. When asked about Resident 2's bedroom and bathroom area, Caregiver E stated it was probably pretty messy. On 10/31/2024, at 10:00 AM, Surveyor interviewed Area Director (AD) D. Surveyor shared concerns observed in the environment. AD D stated staff encouraged Resident 2 to organize his/her belongings and Resident 2 could get triggered when staff cleaned his/her room without him/her present. AD D stated that if it got to the point where food and wrappers were on the floor and exit pathways were not clear, staff should be cleaning and assisting with those tasks. AD D stated s/he discussed the concerns with staff and would ensure cleaning was getting done.	M 276		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as	M 458		

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M 458	Continued From page 4 specified by the pharmacist. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure resident prescription medications remained in their original containers as received from the pharmacy. Medications were prepared ahead of administration and stored in cups. On 07/25/2024, Resident 3 ingested medications from one of those cups that had been prepared for another resident. Findings include: On 07/30/2024, the Department received a death report from the provider. On 10/16/2024, at approximately 11:30 AM, Surveyor interviewed Program Director (PD) B and PD C. PD B stated multiple staff were suspended during an investigation surrounding Resident 3's death and the medication error that occurred on the night prior to his/her death. PD B stated Caregiver H was terminated after the incident and Caregiver H was identified as the caregiver who administered the wrong medications to Resident 3. At 2:00 PM, Surveyor interviewed Caregiver E. Caregiver E stated s/he had worked with Caregiver H on the night of Resident 3's	M 458		

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medication error. Caregiver E stated Caregiver H attempted to give Resident 2 his/her medications but they were not Resident 2's medications. Caregiver E was able to intervene and prevent Resident 2 from receiving the wrong medications. Caregiver E stated Caregiver H realized s/he messed up the medications and Resident 3 received the wrong medications earlier that evening. Caregiver E stated s/he called the 24-hour nurse line for guidance. Caregiver E stated s/he was advised to keep an eye on Resident 3. Caregiver E stated that when the overnight caregiver arrived, Caregiver E was on the phone with Program Supervisor (PS) F. Caregiver E stated s/he told the overnight staff, Caregiver G, to keep an eye on Resident 3.

On 10/17/2024, Surveyor emailed Area Director (AD) D to request Resident 3's records.

On 10/18/2024, Surveyor received an email from AD D with Resident 3's records.

Resident 3 was admitted on 11/01/2017 and had a guardian. Resident 3's Individual Service Plan (ISP), dated 04/08/2024, indicated Resident 3 was diagnosed with Intermittent Explosive Disorder and Moderate Intellectual Disability. Under the "Medication" section of the ISP, it stated staff assisted Resident 3 with ensuring his/her medications were taken correctly.

An internal investigation report, with dates of investigation spanning 7/26/2024 through 8/12/2024, stated, in part, "On 7/25/24, a medication error was made, where at 8pm, [Resident 3] incorrectly received Lamotrigine 200mg, Mirtazapine 45mg, and Simvastatin 40mg. This medication error occurred when [Caregiver H] administered these incorrect

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medications to [Resident 3.] [Resident 3's] scheduled medications are: Fluoxetine HCL 40mg (8am); Lisinopril 10mg (8am); Quetiapine Fumarate 50mg (3:30pm); Quetiapine Fumarate 100mg (8am & 8pm); Divalproex SOD 500mg (8am, 3pm, & 8pm); and Prazosin 1mg (8am, 3pm, & 8pm). Timeline of events: Per [Caregiver E], [s/he] passed 4pm medications to all three residents on 7/25/24 at 4pm. [S/he] prepared all three residents' 8pm medications at that time as well by placing them in medication cups and then back into their drawers in their respective closets. This was a standard practice for [Caregiver E] but is not [Provider's] policy. [Caregiver H] confirmed 8pm medications on 7/25/24 were pre-set in med (medication) cups."

An incident report signed on 7/29/2024, indicated Resident 3 received the wrong medication on 7/25/2024. Under the "Please select the Medication Error Type" section, it stated, "Wrong Person Being Served." Under the "Was there a Serious Adverse Effect associated to this Medication Error?" section, it read, "Yes." Under the "Why Did the Medication Error Happen?" section, it read, "Misidentified person." Under the "Briefly describe the Adverse Effect to the administered medication" section, it read, "Staff had not believed there were adverse effects the night of 7/25 due to [Resident 3] being responsive after the error." Under the "Which medication with dosage caused the adverse effect, if known?" section, it stated, "It is currently both unknown which medication could have caused the adverse effect as well as if the medication error indeed was the cause of the adverse effect."

The July 2024 MAR indicated Resident 3's Quetiapine Fumarate 50 MG Tab was scheduled at 4:00 PM and signed as administered by

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M 458	Continued From page 7 Caregiver E on 07/25/2024. The incident report stated Resident 3 received Mirtazapine 45 MG at 8:00 PM in error on 07/25/2024. Mirtazapine and Quetiapine Interaction Checker - "Serious: Potential for serious interaction; regular monitoring by your doctor required or alternate medication may be needed ...Mirtazapine and Quetiapine both increase causing a dangerous abnormal heart rhythm...Monitor Closely: Significant interaction possible (monitoring by your doctor required) ...Quetiapine and Mirtazapine both increase sedation and drowsiness." (https://www.webmd.com/interaction-checker/default.htm) On 10/31/2024, at 10:00 AM, Surveyor interviewed AD D. Surveyor shared concerns related to medication storage and preparation of medications before administration. AD D stated Caregiver E had prepared the medications ahead of administration time and put them in labeled drawers. AD D stated they retrained Caregiver E on medication administration to ensure s/he understood the process and structure of a medication pass. AD D stated early preparation of medications could have disrupted the process for Caregiver H on the night of Resident 3's medication errors.	M 458		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and	M 466		

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time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that the medication administration records (MAR), for 2 of 2 residents reviewed, showed the administration of the medication.

Resident 1's MAR, from 07/01/2024 - 10/17/2024, contained 85 blank entries.

Resident 2's MAR, from 07/01/2024 - 10/17/2024, contained 67 blank entries.

Findings include:

Example 1 - Resident 1

On 10/16/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 08/01/2012 and had multiple diagnoses, including Intellectual disability, Type 2 Diabetes, Schizoaffective Disorder, and Anxiety and Depression. Resident 1 was documented as requiring staff assistance for medication administration. Surveyor reviewed Resident 1's MAR from 07/01/2024 through 10/17/2024, and observed the following 85 blank entries for his/her prescribed medications:

ARIPIPRAZOLE 5 MG TABLET
07/24/2024 8:00 AM
09/25/2024 8:00 AM
09/26/2024 8:00 AM

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M 466	Continued From page 9 09/27/2024 8:00 AM 10/06/2024 8:00 AM ASPIRIN EC 81 MG TABLET 07/24/2024 8:00 AM 09/25/2024 8:00 AM 09/26/2024 8:00 AM 09/27/2024 8:00 AM 10/06/2024 8:00 AM CLONAZEPAM 1 MG TABLET 07/12/2024 8:00 PM 07/25/2024 8:00 PM 08/2/2024 8:00 PM 09/04/2024 4:30 PM 09/25/2024 8:00 PM 09/26/2024 8:00 PM LEVOTHYROXINE 75 MCG TABLET 07/24/2024 8:00 AM 07/24/2024 7:30 AM 09/25/2024 8:00 AM 09/26/2024 8:00 AM 09/27/2024 8:00 AM 10/06/2024 8:00 AM VIT D3 50MCG SOFTGEL (VIT D3 50MCG SOFTGEL (2000IU)) 08/2/2024 8:00 PM 08/12/2024 8:00 PM 09/04/2024 8:00 PM 09/25/2024 8:00 AM 09/26/2024 8:00 AM 09/25/2024 8:00 PM 09/26/2024 8:00 PM 10/06/2024 8:00 AM OMEPRAZOLE 20MG CAPSULE 08/3/2024 4:30 PM 08/22/2024 4:30 PM	M 466		

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M 466	Continued From page 10 09/04/2024 4:30 PM 09/07/2024 4:30 PM 09/25/2024 4:30 AM 09/26/2024 4:30 AM 09/25/2024 7:30 AM 09/26/2024 7:30 AM 09/27/2024 7:30 AM 10/06/2024 7:30 AM PROPRANOLOL 20 MG TABLET 07/12/2024 8:00 PM 07/24/2024 8:00 AM 07/25/2024 8:00 PM 08/2/2024 8:00 PM 08/3/2024 4:00 PM 08/22/2024 4:00 PM 10/06/2024 8:00 AM QUETIAPINE 50 MG TAB (QUETIAPINE 50MG TABLET) 07/24/2024 8:00 AM 10/06/2024 8:00 AM QUETIAPINE ER 300 MG TABLET 07/12/2024 8:00 PM 07/25/2024 8:00 PM 08/2/2024 8:00 PM 08/12/2024 8:00 PM SERTRALINE 100MG TABLET 07/12/2024 8:00 PM 07/25/2024 8:00 PM 08/2/2024 8:00 PM 08/12/2024 8:00 PM SIMVASTATIN 10MG TABLET 07/12/2024 8:00 PM 07/25/2024 8:00 PM 08/02/2024 8:00 PM 08/12/2024 8:00 PM	M 466		

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M 466	Continued From page 11 09/25/2024 8:00 PM 09/26/2024 8:00 PM 09/25/2024 8:00 PM 09/26/2024 8:00 PM MELATONIN 3MG TABLET 07/12/2024 8:00 PM 07/25/2024 8:00 PM 08/02/2024 8:00 PM 09/04/2024 8:00 PM 09/25/2024 8:00 PM 09/26/2024 8:00 PM METFORMIN ER 500 MG TABLET 07/24/2024 8:00 AM 08/3/2024 4:00 PM 08/22/2024 4:00 PM 09/04/2024 4:00 PM 09/07/2024 4:00 PM 09/25/2024 4:00 PM 09/26/2024 4:00 PM 10/06/2024 8:00 AM LYBALVI 20-10 MG TABLET 07/12/2024 8:00 PM 07/25/2024 8:00 PM 08/02/2024 8:00 PM 09/04/2024 8:00 PM 09/25/2024 8:00 PM 09/26/2024 8:00 PM Example 2 - Resident 2 On 10/16/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 07/09/2012 and had multiple diagnoses, including Type 2 Diabetes, Obsessive Compulsive Disorder, Bipolar Disorder, Static Encephalopathy, and Intermittent Explosive Personality Disorder. Resident 2 was	M 466		

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documented as requiring staff assistance with medication preparation. Surveyor reviewed Resident 2's MAR from 07/01/2024 through 10/17/2024, and observed the following 67 blank entries for his/her prescribed medications:

VITAMIN D2 1.25MG(50,000 UNIT)
07/24/2024 8:00 AM
09/25/2024 8:00 AM

SERTRALINE HCL 100 MG TABLET
07/24/2024 8:00 AM
09/25/2024 8:00 AM
09/26/2024 8:00 AM
09/27/2024 8:00 AM

OMEPRAZOLE DR 20 MG CAPSULE
07/24/2024 8:00 AM
09/25/2024 8:00 AM
09/26/2024 8:00 AM
09/27/2024 8:00 AM

GNP B-50 COMPLEX TABLET
07/12/2024 8:00 AM
07/24/2024 8:00 AM
09/25/2024 8:00 AM
09/26/2024 8:00 AM
09/27/2024 8:00 AM

FARXIGA 5 MG TABLET
07/12/2024 8:00 AM
07/12/2024 8:00 AM
09/25/2024 8:00 AM
09/26/2024 8:00 AM
09/27/2024 8:00 AM

FUROSEMIDE 20 MG TABLET
07/12/2024 8:00 AM
07/24/2024 8:00 AM
07/27/2024 4:00 PM

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REM - KRISTY LANE	1038/1040 KRISTY LANE ONALASKA, WI 54650

(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
M 466	Continued From page 13 08/03/2024 4:00 PM 09/04/2024 4:00 PM 09/25/2024 8:00 AM 09/25/2024 4:00 PM 09/26/2024 4:00 PM 09/26/2024 8:00 AM 09/27/2024 8:00 AM MIRTAZAPINE 45 MG TABLET 09/04/2024 8:00 PM 09/18/2024 8:00 PM 09/25/2024 8:00 PM 09/26/2024 8:00 PM METOPROLOL SUCC ER 25 MG TAB 07/12/2024 8:00 AM 07/24/2024 8:00 AM 09/25/2024 8:00 AM 09/26/2024 8:00 AM 09/27/2024 8:00 AM RISPERIDONE 2 MG TABLET 08/03/2024 4:00 PM 07/12/2024 8:00 AM 07/24/2024 8:00 AM 09/25/2024 8:00 AM 09/26/2024 8:00 AM 09/27/2024 8:00 AM 09/25/2024 4:00 PM 09/26/2024 4:00 PM METFORMIN HCL ER 500 MG TABLET 07/12/2024 8:00 AM 09/25/2024 8:00 AM 09/26/2024 8:00 AM 09/27/2024 8:00 AM SIMVASTATIN 40 MG TABLET 09/04/2024 8:00 PM 09/18/2024 8:00 PM	M 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011302	A. BUILDING: _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM - KRISTY LANE	1038/1040 KRISTY LANE ONALASKA, WI 54650

(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
M 466	Continued From page 14 09/25/2024 8:00 PM 09/26/2024 8:00 PM VITRON C 09/25/2024 8:00 AM 09/27/2024 8:00 AM LAMOTRIGINE 200 MG TABLET 09/04/2024 8:00 PM 09/18/2024 8:00 PM 09/25/2024 8:00 PM 09/26/2024 8:00 PM LOSARTAN POTASSIUM 25 MG TAB 09/25/2024 8:00 AM 09/26/2024 8:00 AM 09/27/2024 8:00 AM SPIRONOLACTONE 25 MG TABLET 09/25/2024 8:00 AM 09/26/2024 8:00 AM 09/27/2024 8:00 AM On 10/31/2024 at 10:00 AM, Surveyor interviewed Area Director (AD) D. Surveyor shared concerns related to the number of blank areas on the MARs. AD D stated program supervisors had access to make corrections to the electronic MARs for 24 hours. AD D stated staff were instructed to use paper MARs in the event of internet interruptions and log-in issues. AD D stated they reviewed the paper MARs and made necessary edits to the electronic MARs once per month. AD D stated the nurse had been doing the MAR audits and s/he would speak with the nurse regarding the blank areas on the MARs.	M 466		