STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016640	A. BUILDING: _____ B. WING _____	C 08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLSOM REM WISCONSIN III INC	2111 FOLSOM ST EAU CLAIRE, WI 54701

(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 08/05/2024, Surveyor conducted an abbreviated survey at Folsom REM Wisconsin III Inc. Data collection continued through 08/09/2024. Two deficiencies were identified. Census: 4	M 000		
M 244	88.04(5)(a) TRAINING-15 HOURS WITHIN 6 MONTHS The licensee and each service provider shall complete 15 hours of training approved by the licensing agency related to health, safety and welfare of residents, resident rights and treatment appropriate to residents served prior to or within 6 months after starting to provide care. This training shall include training in fire safety and first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 employees reviewed, completed training in first aid within 6 months after starting to provide care. Findings include: On 08/05/2024, Surveyor requested to review employee records. Caregiver C had a hire date of 06/26/2023. Caregiver B's record did not contain documentation of training in first aid within 6	M 244		

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

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M 244	Continued From page 1 months. Caregiver D had a hire date of 02/03/2023. Caregiver C's record did not contain documentation of training in first aid within 6 months. On 08/09/2024 at 10:09 AM, Program Director B stated via email, "...Unfortunately, I wasn't able to find the trainings for [Caregiver D] or [Caregiver C] for First Aid. [Caregiver D] did complete first aid on 2/11/2024 (1 year after hire date) and I have sent [Caregiver C] to the training for that as well."	M 244		
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 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 observation, record review and interview, the provider did not keep a record of all prescription medications controlled, dispensed, or administered, for Resident 1 and Resident 2. Findings include: RESIDENT 1	M 466		

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M 466	Continued From page 2 On 08/05/2024 at approximately 9:10 AM, Surveyor observed the medication storage closet with Caregiver A. Surveyor observed several pills in the bottom of the medication box container for Resident 1. Surveyor asked Caregiver A why the pills were not in original packaging. Caregiver A stated s/he had popped the pills and placed them in a cup and placed the cup in the container because Resident 1 was not ready to take them. The medications included: Docusate sodium 100mg soft gel Famotidine 40mg tablet Fluoxetine HCL 20mg capsule Fluoxetine HCL 10mg capsule Methylphenidate ER 20mg tablet Caregiver A placed the pills back into the clear medication cup and placed the cup on the kitchen counter with 2 residents present and walked back into the staff office. Program Director (PD) B directed Caregiver A to administer them immediately. Surveyor requested count sheets for Methylphenidate ER 20mg tablets. The count sheet showed 2 tablets were remaining, but there was only 1 pill in the pack. Caregiver A stated s/he punched the pill from the pack but did not administer it or record it at that time. Surveyor observed another full pack of Methylphenidate ER 20mg tablets in the medication closet. The medications were not accounted for in the medication administration record (MAR) count sheets. Caregiver A stated they were just delivered so s/he had not recorded them in the MAR yet. PD B located the delivery sheet, which showed the pack was delivered on	M 466		

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M 466	Continued From page 3 08/02/2024, 3 days prior. RESIDENT 2 On 08/05/2024 at approximately 9:15 AM, Surveyor observed Resident 2's Clonazepam controlled card of medication. The card had a physical count of 27. Caregiver A provided Surveyor with the count sheet which had a different medication name listed ("Clonazepine" [sic]) and showed a total of 37 pills remaining on the count sheet. Caregiver A and PD B could not determine why the count was off. On 08/09/2024 at 10:09 AM, PD B stated via email, "[Caregiver A] was not sure what to do when you came and just didn't complete what [s/he] was doing at the time so meds (medications) were in a cup. We did go over this together and [s/he] feels more confident now. The medication count that was off I was not able to figure that out [sic] but we did fix the count and are having a staff meeting to retrain the staff on this issue." On 08/09/2024 at 2:50 PM, PD B further stated via email, "I have talked with [Caregiver A] and the staff about the importance continuing the tasks at hand as not to interrupt the routine unless of course it is an emergency." The provider did not ensure Resident 1's medication controlled, dispensed, and administered, were properly documented in the MAR. The provider did not ensure Resident 2's medications were accounted for at the time of delivery.	M 466		