STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017754	A. BUILDING: _____ B. WING _____	R-C 10/18/2023

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SV SOUTH BELOIT EAST	2775 KADLEC DR BELOIT, WI 53511

(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 10/17/2023, Surveyors conducted a standard survey and 1 verification visit at SV South Beloit East. Nine deficiencies were identified. Five of the 9 deficiencies were repeat violations. See Statement of Deficiency (SOD) #Z7JO11, dated 04/24/2020, SOD #S66I11, dated 04/27/2022, SOD #S66I12, dated 12/28/2022, and SOD #S66I13, dated 05/18/2023. One of 6 violations from SOD #S66I13, dated 05/18/2023 was corrected. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 5	{N 000}		
{N 196}	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the provider complied with all laws governing the CBRF (community-based residential facility). This is a repeat violation. See Statement of Deficiency (SOD) S66I11, dated 04/27/2022, SOD S66I12, dated 12/28/2022, and SOD S66I13, dated 05/18/2023.	{N 196}		

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

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{N 196}	Continued From page 1 Findings include: The provider was licensed, on 10/01/2019, as a class CNA (nonambulatory) CBRF able to serve up to 18 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, terminally ill, and physically disabled. On 10/17/2023, Surveyors conducted a standard licensure survey and a verification visit. As a result of the survey, nine deficiencies were identified with five being repeat deficiencies: -N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws. This deficiency is being cited for a fourth time. See SOD S66I11, dated 04/27/2022, SOD S66I12, dated 12/28/2022, and SOD S66I13, dated 05/18/2023. -N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication. This deficiency is being cited for a fourth time. See SOD Z7JO11 dated 04/24/2020, SOD S66I11 dated 04/27/2022, SOD S66I12, dated 12/28/2022, and SOD S66I13, dated 05/18/2023. -N0415 DHS 83.37(2)(d) Documentation of Medication Administration. This deficiency is being cited for a fourth time. See SOD S66I11 dated 04/27/2022 and SOD S66I12, dated 12/28/2022, and SOD S66I13, dated 05/18/2023. -N0431 DHS 83.38(1)(g) Health Monitoring. This deficiency is being cited for a third time. See SOD S66I11, dated 04/27/2022, and SOD S66I13, dated 05/18/2023. -N0617 DHS 83.55(6)(b) Bath and Toilet Areas: Water Temperatures. This deficiency is being cited for a fourth time. See SOD S66I11, dated	{N 196}		

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{N 196}	Continued From page 2 04/27/2022, and SOD S66I12, dated 12/28/2022, and SOD S66I13, dated 05/18/2023. Review of facility records documented four previous survey events identifying noncompliance, as follows: SOD S66I13 On 04/25/2023, Surveyors conducted 1 verification visit at SV South Beloit East. Six deficiencies were identified. Six of 6 deficiencies were repeat violations. N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws - REPEAT N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication - REPEAT N0415 DHS 83.37(2)(d) Documentation of Medication Administration - REPEAT N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet - REPEAT N0431 DHS 83.38(1)(g) Health Monitoring - REPEAT N0617 DHS 83.55(6)(b) Bath And Toilet Areas: Water Temperature - REPEAT SOD S66I12 - dated 12/28/2022 On 12/06/2022, Surveyors conducted 1 verification visit and 2 complaint investigations at SV South Beloit East. Thirteen deficiencies were identified. Seven of 13 deficiencies were repeat violations Two of 2 complaints were substantiated. N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws - REPEAT N0203 DHS 83.14(2)(h) Posting: License, Deficiencies, Revocations	{N 196}		

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{N 196}	Continued From page 3 N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication - REPEAT N0369 DHS 83.34(2)(c) Written Report of Resident Account N0415 DHS83.37(2)(d) Documentation of Medication Administration - REPEAT N0419 DHS 83.37(3)(c) Medication Storage: Locked Cabinet N0427 DHS 83.38(1)(c) Leisure Time Activities - REPEAT N0432 DHS 83.38(1)(h) Medication Administration - REPEAT N0439 83.38(1) Infection Control Program N0502 83.46(1)(a) Comfortable and Safe Temperatures N0539 DHS 83.48(3)(b) Sensitivity Testing Performed - REPEAT N0617 DHS 83.55(6)(b) Bath And Toilet Areas: Water Temperature - REPEAT SPECIAL ORDERS: Pursuant to Wis. Stat. § 50.03(5g)(b)6., EFFECTIVE IMMEDIATELY, the licensee shall ensure the provision of services to meet residents' physical and mental health needs. For medical and health monitoring related violations identified in Statement of Deficiency (SOD) S66I11, the licensee shall develop and implement corrective measures in consultation with a registered nurse (RN). ... Consultation will include the development (or revision) of written procedures and staff training (as appropriate) to address: Medication Management and Administration - Including how the facility will: (a) document medication orders, medication administration, and missed/refused doses; (b) administer medications to ensure residents receive medications at the intervals and dosages prescribed; (c) prevent medication errors; (d) respond to medication errors if they occur; (e) monitor for adverse side effects; (f) ensure	{N 196}		

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{N 196}	Continued From page 4	{N 196}		

medications are securely stored; g) monitor for adverse side effects; (h) discontinue and dispose of medications; and (i) document and maintain proof of use record for schedule II drugs.

SOD S66I11 - dated 04/27/2022
On 03/29/2022, with information gathered through 04/27/2022, Surveyor conducted a standard licensure survey, a complaint investigation, and a self-report review at SV South Beloit East. Twenty-three deficiencies were identified.

One of the 23 deficiencies was a repeat violation (see Statement of Deficiency (SOD) Z7JO11). Complaint was substantiated.

N0158 DHS 83.12(2)(a) Caregiver: Investigating Abuse & Neglect
N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws
N0277 DHS 83.25 Continuing Education
N0306 DHS 83.28(7) Advanced Directives
N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment
N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication - REPEAT
N0353 DHS 83.32(3)(i) Rights of Residents: Adequate Treatment
N0358 DHS 83.32(3)(n) Rights of Residents: Safe Environment
N0392 DHS 83.35(4) Resident Satisfaction Evaluation
N0404 DHS 83.37(1)(e) Medication Regimen, Administration Review
N0408 DHS 83.37(1)(i) PRN Psychotropic Medication
N0410 DHS 83.37(1)(k) Medication Error or Adverse Reaction
N0415 DHS 83.37(2)(d) Documentation of Medication Administration

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{N 196}	Continued From page 5 N0427 DHS 83.38(1)(c) Leisure Time Activities N0431 DHS 83.38(1)(g) Health Monitoring N0432 DHS 83.38(1)(h) Medication Administration N0435 DHS 83.38(1)(k) Transportation N0445 DHS 83.41(1)(a) Food Supply N0448 DHS 83.41(2)(a) Nutrition: Diet N0539 DHS 83.48(3)(b) Sensitivity Testing Performed N0617 DHS 83.55(6)(b) Bath And Toilet Areas: Water Temperature Y3234 DHS 50.09(1)(e) Treatment SPECIAL ORDERS: . Pursuant to Wis. Stat. § 50.03(5g)(b)6., EFFECTIVE IMMEDIATELY, the licensee shall ensure the provision of services to meet residents' physical and mental health needs. For medical and health monitoring related violations identified in Statement of Deficiency (SOD) S66I11, the licensee shall develop and implement corrective measures in consultation with a registered nurse (RN). ... Consultation will include the development (or revision) of written procedures and staff training (as appropriate) to address: Medication Management and Administration, Health Monitoring, and Diabetes Management, to include standards of practice for the assessment, care planning, and provision of services for residents with diabetes. SOD Z7JO11 On 04/20/2020, Surveyor conducted a remote standard survey for SV South Beloit East. Five deficiencies were identified. N0164 Reporting When Law Enforcement is Called N0301 Provide Admission Agreement as Required N0352 DHS 83.32(3)(h) Rights of Residents:	{N 196}		

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{N 196}	Continued From page 6 Receive Medication N0389 DHS Service Plans Updated Annually Or On Changes N0416 DHS Other Administration Given Or Delegated by RN SPECIAL ORDERS: Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b)3. and (b)6., the licensee will correct all violations identified in SOD Z7JO11 and will achieve substantial compliance with all laws and administrative rules governing the facility and its operation prior to expiration of the facility's Probationary License. On 10/17/2023 at 2:30 PM, Surveyors discussed concerns regarding repeat violations with Consultant/Interim Administrator AA and House Manager W. Consultant/Interim Administrator AA stated the revolving door of staff made it difficult to train and retrain new staff, but progress had been made.	{N 196}		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure the resident right to receive all prescribed medications in the dosage and at intervals prescribed by a	{N 352}		

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{N 352}	Continued From page 7	{N 352}		

practitioner for 2 of 3 residents reviewed.

Resident 3's Diclofenac Sodium Topical 1% Gel was not administered as ordered when 12.5 days' worth remained in unopened box dispensed 09/09/2023.

Resident 5's Potassium CL 10 % was not administered as ordered when approximately half a bottle remained on 10/17/2023 in a 31 dose bottle opened 09/11/2023.

This is a repeat violation. See Statement of Deficiency (SOD) Z7JO11, dated 04/24/2020, SOD S66I11, dated 04/27/2022, and SOD S66I12, dated 12/28/2022, and SOD S66I13, dated 05/18/2023.

Findings include:

The facility is licensed as a Class CNA (non-ambulatory) CBRF able to serve up to 8 residents within the client groups of advanced age, terminally ill, physically disabled and irreversible dementia/Alzheimer's. Census on 10/17/2023 was 5.

On 10/17/2023 at 9:27 AM, Surveyor inspected the medication cart with Caregiver CC.

Example 1- Resident 3
Two tubes of Resident 3's Diclofenac Sodium Topical 1% Gel were in the medication cart. One was unopened tube with puncture seal intact, and the second was in its original unopened box.

Pharmacy label on box identified (Photo1):
Name of facility's pharmacy.
Dispense date 09/08/2023.
Diclofenac Sodium Topical 1% Gel Apply 2 grams

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{N 352}	Continued From page 8 topically to left ankle 4 times daily for pain. Manufacturers label identified: Net weight 100 grams. On 10/17/2023, Surveyor reviewed Resident 3's record. S/he was admitted 01/27/2017. Physician orders included: Diclofenac Sodium Topical 1% Gel Apply 2 grams topically to left ankle 4 times daily for pain. Individual Service Plan dated 03/23/2023: In the area of Medication Management- "FULL ASSIST...Team Member to administer medications as they are ordered by MD..." Medication Administration Record (MAR) dated 09/01/2023-10/17/2023: From 09/03/2023 thru 10/17/2023 AM, staff documented administration of Diclofenac gel 173 times (totaling 44 days), including Caregiver CC's documentation of 10/17/2023 AM dose. Staff documented "other" on 09/19/2023 at 11:05 AM. On 10/18/2023 at 1:19 PM, Surveyor received Resident 3's observation notes dated 09/01/2023-10/17/2023 from House Manage W via email. No documentation contained in observation notes of staff not administering Diclofenac gel or Resident 3 refusing it. Example 2- Resident 5 One bottle of Resident 5's liquid Potassium CL 10 % was in the medication cart. Pharmacy label identified (Photo 2): Potassium CL 10 % (20 MEQ/473 ML) give 15 ML daily for CAD (coronary artery disease). Dispense date 09/09/2023. Handwritten on the bottle was "Opened 9/11". The bottle was approximately half full.	{N 352}		

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{N 352}	Continued From page 9 On 10/17/2023, Surveyor reviewed Resident 5's record. S/he was admitted on 01/27/2023. On 10/12/2023 s/he was admitted to hospital sometime after AM medication pass. Physician orders included Potassium CL 10% (20 MEQ/15ML) take 15 ML daily for CAD. ISP (not dated): In the area of Medication Management- "FULL ASSIST...Receive Medications as they are ordered bt my MD Who is responsible for interventions: Team Member..." MAR: Staff documented administration of Potassium CL 10% daily 09/11/2023 thru 10/12/2023 AM totaling 31 doses/days. Observation Notes dated 09/01/2023-10/12/2023 (date of admission to hospital): No documentation contained in observation notes regarding Potassium CL 10% not being administered. On 10/17/2023 at 9:27 AM while inspecting the medication cart with Caregiver CC, Surveyor interviewed Caregiver CC who stated staff administered all medications to Resident 3 and Resident 5. Caregiver CC stated Resident 3 often refused the Diclofenac Gel and had refused it 10/17/2023 AM because Resident 3 preferred Tylenol for neck and shoulder pain. Caregiver CC stated s/he did not know where the opened tube of gel was because it was either empty or expired and the unopened tube and box were in the med cart 10/17/2023 AM. Caregiver CC stated s/he did not know how to get a refills from the pharmacy. Caregiver CC examined Resident 5's bottle of Potassium CL 10% and stated it was just under half full. When Surveyor asked why the	{N 352}		

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{N 352}	Continued From page 10 bottle was still half full when opened on 09/11/2023, Caregiver CC stated Resident 5 was hospitalized. On 10/17/2023 at 2:12 PM, Surveyor returned the medication cart with Interim Administrator AA and showed him/her Resident 3's unopened Diclofenac gel and Resident 5's liquid Potassium CL. Interim Administrator AA stated Resident 3's unopened box was prescribed by Physician FF. Administrator AA examined Resident 5's bottle of liquid Potassium and stated it was over half full. When Surveyor asked if s/he expected the bottle to be empty if opened 09/11/2023, Administrator AA stated, "I'm not answering that." On 10/17/2023, Surveyor reviewed the pharmacy manifest delivery confirmation which stated 200 grams of Resident 3's Diclofenac Sodium 1% Gel and 473 ML's of Resident 5's Potassium CL 10% was delivered on 09/09/2023 On 10/17/2023 at 2:41 PM, Surveyor discussed concern of medications not administered as ordered with Interim Administrator AA and House Manager W. Administrator AA stated s/he could not explain the Resident 5's liquid Potassium and they would implement medication cart monitoring. On 10/18/2023 at 10:56 AM, Surveyor interviewed Pharmacy Tech DD who stated on 09/08/2023, pharmacy dispensed 2 tubes totaling 200 grams/25 days' worth of Resident 3's Diclofenac gel and staff needed to notify pharmacy when refills were needed. Pharmacy Tech DD stated on 09/09/2023 the pharmacy dispensed 473 MLs/31 days' worth of Resident 5's liquid Potassium CL 10 % and staff needed to notify pharmacy when refills were needed.	{N 352}		

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{N 352}	Continued From page 11 Cross Reference: N0415 DHS 83.37(2)(d) Documentation of Medication Administration N0431 DHS 83.38(1)(g) Health Monitoring	{N 352}		
{N 415}	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure at the time of medication administration, the person administering the medication documented in the resident record the name, dosage, date, and time of medication taken and initialed the medication administration record. From 09/08/2023-10/16/2023, number of units of sliding scale insulin administered were not documented for Resident 10. This is a repeat violation. See Statement Of Deficiency (SOD) S66I11, dated 04/27/2022, and SOD SS6I12, dated 12/28/2022, and SS6I13	{N 415}		

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{N 415}	Continued From page 12 dated 05/18/2023. Findings include: On 10/17/2023, Surveyor reviewed Resident 10's record. S/he was admitted 04/05/2022. Diagnoses included type 2 diabetes mellitus. Physician orders included: Humalog 12 UNITS subcutaneously 3 times daily with meals, hold for blood sugars less than 100 (start date 09/08/2023), and Humalog 200 UNIT/ML Kwikpen sliding scale (start date 09/08/2023): 200-250=2 UNITS 251-300=4 UNITS 301-350=6 UNITS 351-400=8 UNITS 401-450=10 UNITS 451-500=12 UNITS. Over 501 call MD. Medication Administration Record dated 09/08/2023-10/16/2023- From 09/08/2023-10/16/2023, staff documented administration of Humalog 200 UNIT/ML Kwikpen sliding scale insulin 116 times. Number of UNITs of sliding scale insulin administered was not documented on the MAR. Care History dated 09/08/2023-10/16/2023- The Care History identified Humalog 200 UNIT/ML Kwikpen (no specification if scheduled 12 UNITS or sliding scale), date, time, blood sugar reading, and insulin injection site or n/a if no insulin was administered. Number of UNITS of sliding scale insulin administered was not documented in the Care History. Observation Notes dated 09/08/2023-10/16/2023- Staff did not document number of UNITS of	{N 415}		

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{N 415}	Continued From page 13 sliding scale insulin administered in the observation notes. On 10/17/2023 at 2:41 PM, Surveyor discussed concern of not documenting number of UNITS of sliding scale insulin administered with Interim Administrator AA and House Manager W. Interim Administrator AA stated the electronic MAR system did not prompt staff to document the number of UNITS and they would not know how many UNITS were administered if not documented. Cross Reference: N0415 DHS 83.37(2)(d) Documentation of Medication Administration N0431 DHS 83.38(1)(g) Health Monitoring	{N 415}		
N 420	83.37(3)(d) Medication storage: refrigeration Refrigeration. Medications stored in a common refrigerator shall be properly labeled and stored in a locked box. This Rule is not met as evidenced by: Based on observation and interview, medications stored in the medication refrigerator were not stored in a secure manner and stored at a temperature of zero degrees. Findings include: The facility is licensed as a Class CNA (non-ambulatory) CBRF able to serve up to 8 residents within the client groups of advanced age, terminally ill, physically disabled and irreversible dementia/Alzheimer's. Census on 10/17/2023 was 5.	N 420		

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N 420	Continued From page 14 On 10/17/2023, at approximately 8:25 AM, Surveyor conducted a tour of the facility and observed the unlocked kitchen door that was partially opened. Surveyor entered the kitchen and observed another door. The door was unlocked, and Surveyor observed the unsecured medication refrigerator which contained 4 boxes of Novolog insulin which contained 5 pre-filled pens labeled for Resident 10. On 10/17/2023, at approximately 1:30 PM, Surveyor showed Consultant/Interim Administrator AA the unlocked refrigerator that contained the insulin. Surveyor stated the thermometer reads 0° Fahrenheit. Surveyor stated there is ice build up around the freezer compartment. Consultant/Interim Administrator AA stated the refrigerator would be replaced. "Insulin from various manufacturers is often made available to patients in an emergency and may be different from a patient's usual insulin. After a disaster, patients in the affected area may not have access to refrigeration. According to the product labels from all three U.S. insulin manufacturers, it is recommended that insulin be stored in a refrigerator at approximately 36°F to 46°F. Unopened and stored in this manner, these products maintain potency until the expiration date on the package. ... You should try to keep insulin as cool as possible. If you are using ice, avoid freezing the insulin. ... Insulin loses some effectiveness when exposed to extreme temperatures. The longer the exposure to extreme temperatures, the less effective the insulin becomes. This can result in loss of blood glucose control over time." (Source: FDA U.S. Food & Drug Administration website, Information Regarding Insulin Storage and Switching Between Products in an Emergency, 09/19/2017,	N 420		

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N 420	Continued From page 15 https://www.fda.gov/drugs (retrieval date - October 18, 2023).	N 420		
{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 changes in the resident ' s health or mental health status in the resident ' s record.	{N 431}		

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{N 431}	Continued From page 16	{N 431}		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the CBRF monitored the health of residents as ordered by the physician for 1 of 2 residents reviewed.

Staff administered Resident 6's Metoprolol without a prior pulse reading 13 times from 09/03/2023-10/17/2023 staff did not take Resident 6's pulse prior to administering Metoprolol as ordered by physician.

This is a repeat deficiency. See Statement Of Deficiency (SOD) S66I11, dated 04/27/2022, and S66I13, dated 05/18/2023.

Findings include:

The facility is licensed as a Class CNA (non-ambulatory) CBRF able to serve up to 8 residents within the client groups of advanced age, terminally ill, physically disabled and irreversible dementia/Alzheimer's.

On 10/17/2023, Surveyor reviewed Resident 6's record. S/he was admitted 10/04/2013. Diagnoses included hypertension and coronary artery disease.

Physician orders included Metoprolol Tart 50 MG 1 tablet twice daily for high blood pressure, hold if pulse is less than 50 (start date 07/24/2023) and weekly vitals including pulse (start date 08/02/2023).

Vitals History dated 09/03/2023-10/17/2023:
No or only 1 pulse reading was documented on:
09/03/2023- 7:40 PM
09/08/2023- 7:59 PM

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{N 431}	Continued From page 17 09/12/2023- 7:56 AM 09/15/2023- 7:24 PM 09/16/2023- (none) 09/17/2023- (none) 09/18/2023- 7:13 PM 09/28/2023- 7:21 PM 10/01/2023- 7:13 PM 10/06/2023- 7:27 AM 10/15/2023- 7:36 PM Observation Notes dated 09/01/2023-10/17/2023: Observation notes did not contain pulse readings. Medication Administration Record dated 09/01/2023-10/17/2023: From 09/03/2023-10/17/2023, staff documented administration of Metoprolol with no pulse reading on: 09/03/2023 AM 09/08/2023 AM 09/12/2023 PM 09/15/2023 AM 09/16/2023 AM and PM 09/17/2023 AM and PM 09/18/2023 AM 09/28/2023 AM 10/01/2023 AM 10/06/2023 PM 10/15/2023 AM Individual Service Plan (ISP) signed and dated 03/23/2023 and 09/19/2023: In the area of Medication Management: "FULL ASSIST...Receive Medications [sic] as they are ordered my [sic] MD...Team Member to administer medications as they are ordered by MD..." On 10/17/2023 at 1:14 PM, Surveyor interviewed	{N 431}		

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{N 431}	Continued From page 18 House Manager W and Interim Administrator AA. House Manager stated Resident 6's pulse readings may have been documented in the observation notes. Interim Administrator AA stated they would not know if pulse was taken or not if pulse readings were not documented. On 10/17/2023 at 2:41 PM, Surveyor discussed concern of not taking pulse readings as ordered by physician with Interim Administrator AA and House Manager W. Interim Administrator AA stated they were not able to determine if Resident 6's pulse was taken or not, it was the same caregiver for each incident and that caregiver would be terminated from employment on 10/17/2023. Cross Reference: N0352 DHS 83.37(3)(h) Rights Of Residents: Receive Medication N0415 DHS 83.37(2)(d) Documentation of Medication Administration	{N 431}		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 3 of 5 rooms were clean and free from odor (Resident 6's, Resident 10's and Resident 11's). Findings include: On 10/17/2023, at approximately 8:40 AM, Surveyor toured the facility and noted that when	N 489		

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N 489	Continued From page 19	N 489		

s/he was standing near the medication. cart, s/he detected a urine-like scent emanating from Resident 10's room. Surveyor entered Resident 10's room and spoke with Resident 10. Surveyor noted the urine-like scent was prominent in his/her room. Surveyor observed laundry baskets full of clothing.

On 10/17/2023, at approximately 8:50 AM, Surveyor interviewed Caregiver CC. Surveyor commented to Caregiver CC that Resident 10's bedroom had a strong urine-like scent. Caregiver CC stated that s/he had sinus issues and was unable to smell. Caregiver CC explained that Resident 10 dealt with incontinence, but changed him/herself independently, and the laundry baskets are probably full of soiled clothing, as Resident 10 does not like staff to do his/her laundry.

On 10/17/2023, at approximately 9:10 AM, Surveyor toured Resident 11's bedroom. Surveyor noted a urine-like scent that was prominent in his/her room. Surveyor leaned over and smelled the seating area of Resident 11's cloth recliner and noted an overpowering urine-like scent.

On 10/17/2023, at approximately 9:30 AM, Surveyor interviewed Consultant/Interim Administrator AA. Surveyor explained the observations of Resident 10's and Resident 11's room. Consultant/Interim Administrator AA stated that s/he did not feel that Resident 10's room had a strong urine-like scent, but it was probably Resident 6's room, which is next to Resident 10's room.

On 10/17/2023, at approximately 10:00 AM, Surveyor toured Resident 6's bedroom. Surveyor

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N 489	Continued From page 20 observed an overpowering urine-like scent. On 10/17/2023 at 2:30 PM, Surveyors discussed concerns regarding repeat violations with Consultant/Interim Administrator AA and House Manager W. Consultant/Interim Administrator AA stated s/he would observe the furniture in the resident rooms to determine if that was the cause of the urine-like scent. Consultant/Interim Administrator A stated that s/he would discuss Resident 10's behavior regarding his/her laundry and determine if there is a way to redirect him/her to allow his/her laundry to be washed on an as needed basis.	N 489		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were stored in a secured area. Surveyor observed the unlocked kitchen door that upon entrance one could walk through door that stored the cleaning compounds. Findings include: The facility is licensed as a Class CNA (non-ambulatory) CBRF able to serve up to 8 residents within the client groups of advanced age, terminally ill, physically disabled and irreversible dementia/Alzheimer's. Census on 10/17/2023 was 5.	N 499		

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N 499	Continued From page 21 On 10/17/2023, at approximately 9:10 AM, Surveyor conducted a tour of the facility and observed the unlocked kitchen door that was partially opened. Surveyor entered the kitchen and observed another door. The door was unlocked and Surveyor observed the following cleaning compounds: - 14.6 ounce spray can of air freshener - (2) 28 fluid ounce bottle of calcium, lime & rust remover - (2) gallon jugs of bleach - 1 gallon jug of floor cleaner & degreaser - 1 quart spray bottle of bleach water - (6) 24 fluid ounce bottles of gel toilet bowl cleaner - Opened bag of dishwasher pods - 7 ounce spray can of smoke odor neutralizer This area was accessible to all residents. Residents were observed ambulating freely throughout the facility. The kitchen is located directly off of the dining room and occupied resident rooms 1, 2, and 3 can be seen while standing in the kitchen. On 10/17/2023 at 2:30 PM, Surveyors discussed concerns regarding repeat violations with Consultant/Interim Administrator AA and House Manager W. Consultant/Interim Administrator AA stated all doors to the laundry room/storage room are to be locked.	N 499		
N 523	83.47(2)(b) Exit diagram. Exit diagram. The disaster plan shall have an exit diagram that shall be posted on each floor of the CBRF used by residents in a conspicuous	N 523		

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N 523	Continued From page 22	N 523		

place where it can be seen by the residents. The diagram shall identify the exit routes from the floor, including internal horizontal exits under par. (f) when applicable, smoke compartments or a designated meeting place outside and away from the building when evacuation to the outside is the planned response to a fire alarm.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that 4 out of 4 posted exit diagrams accurately reflected the facility's exit routes.

Findings include:

The facility is licensed as a Class CNA (non-ambulatory) CBRF able to serve up to 8 residents within the client groups of advanced age, terminally ill, physically disabled, and irreversible dementia/Alzheimer's. Census on 10/17/2023 was 5.

On 10/17/2023, Surveyors toured the facility. The facility has resident rooms on the first floor, on both sides of the building. Surveyors observed the following exit diagrams:

- Evacuation Route posted at main entrance displayed the route for occupied Bedrooms 1, 2 and 3, the Dining Room, and the Living Room to exit out the main entrance door. The second emergency exit was not identified.
- Evacuation Route posted by occupied Bedroom 4 displayed the emergency route to the main entrance but did not identify the second emergency exit.
- Evacuation Route posted between Bedroom 5 and occupied Bedroom 6, displayed the emergency exit for Bedroom 6 to utilize the

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N 523	Continued From page 23 second emergency exit but did not identify the main entrance door as an emergency exit. Bedroom 5 did not have an outlined emergency exit. - Evacuation Route posted by Bedroom 7 displayed the route for occupied Bedrooms 1, 2 and 3, the Dining Room, and the Living Room to exit out the main entrance door. Surveyor also observed the exit sign with the arrow sign for the emergency exit door, between Bedroom 5 and Bedroom 6, was burnt out. The exit sign located above the emergency exit door, next to Bedroom 7, was half luminated. On 10/17/2023 at 2:30 PM, Surveyors discussed concerns regarding repeat violations with Consultant/Interim Administrator AA and House Manager W. Consultant/Interim Administrator AA stated new exit diagrams would be created and posted accordingly.	N 523		
{N 617}	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that water temperatures at faucets	{N 617}		

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{N 617}	Continued From page 24	{N 617}		

in residential bathrooms did not exceed 115 degrees Fahrenheit. Two of 2 water temperatures taken exceeded 115 degrees Fahrenheit.

This is a repeat deficiency. See Statement of Deficiency (SOD) S66I11, dated 08/12/2022, S66I12, dated 12/28/2022, and SOD S66I13, dated 05/18/2023.

Findings include:

The facility is licensed as a Class CNA (nonambulatory) CBRF able to serve up to 8 residents within the client groups of advanced age, terminally ill, physically disabled, and irreversible dementia/Alzheimer's. Census on 10/17/2023 was 5.

On 10/18/2023, at approximately 8:45 AM, Surveyors measured temperature of the water in 2 resident bathrooms at the sink:
Resident bathroom 1 (near resident room 1) - Water temperature measured 126.4 degrees Fahrenheit.
Resident bathroom 2 (near resident room 6) - Water temperature measured 136.6 degrees Fahrenheit.

On 10/17/2023 at 2:30 PM, Surveyors discussed concerns regarding repeat violations with Consultant/Interim Administrator AA and House Manager W. Consultant/Interim Administrator AA stated maintenance had been monitoring the water temperature and adjusting as required. Consultant/Interim AdministratorAA stated s/he would have maintenance adjust the heat regulator on the hot water tank again.

Cross Reference:
N0196 DHS 83.14(2)(a) Licensee Ensures

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{N 617}	Continued From page 25 Facility Complies With Laws	{N 617}		