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N 000	Initial Comments On 09/18/2023, Surveyor conducted a standard survey at REM Jonathon. Seven deficiencies were identified. One of 7 deficiencies was a repeat violation. See statement of deficiency (SOD) #F74C11, dated 10/22/2019. Census: 6	N 000		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties.	N 239		

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

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N 239	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 employees reviewed obtained all department-approved training as required. Caregiver B did not have training in fire safety. Findings include: On 09/18/2023, Surveyor conducted a review of 3 employee to verify compliance with department-approved training requirements. Surveyor requested training records from Administrator A. Fire Safety: The record for Caregiver B, hired 09/15/2017, did not contain evidence of training or evidence of meeting an exemption for fire safety. On 09/18/2023, Surveyor verified Caregiver B was not on the CBRF training registry for fire safety. On 09/18/2023 at 2:18 PM, Surveyor conducted an exit conference and shared findings with Administrator A. Administrator A noted s/he assumed Caregiver B had all CBRF department approved training. Administrator A stated s/he will sign Caregiver B up for fire safety as soon as possible.	N 239		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise	N 243		

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N 243	Continued From page 2 ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group. Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment.	N 243		

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N 243	Continued From page 3	N 243		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that 1 of 3 employees reviewed completed training in all employee training. Caregiver D did not have documentation for completion of training in client groups or challenging behaviors.

Findings include:

On 09/18/2023, Surveyor conducted a review of 3 employees to verify compliance with all employee training requirements. Surveyor requested training records from Administrator A.

Client Group:

The record for Caregiver D, hired 08/04/2022, did not contain evidence of training or evidence of meeting an exemption for client group training.

Recognizing, Preventing, Managing and Responding to Challenging Behaviors:

The record for Caregiver D, hired 08/04/2022, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training.

On 09/18/2023 at 2:18 PM, Surveyor conducted an exit conference and shared findings with Administrator A. Administrator A stated s/he would need to talk to Caregiver D's supervisor to ensure all employee training was being completed within 90 days of hire. Administrator A did not provide a reason to why Caregiver D did

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N 243	Continued From page 4 not have all employee training completed.	N 243		
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 2 of 2 employees (who required continuing education) completed at least 15 hours of continuing education in 2022. Findings include: On 09/18/2023, Surveyor reviewed employee files and identified the following: Caregiver B was hired 09/15/2017. Caregiver B's record included approximately 11.25 hours of continuing education training for 2022. Program Supervisor C was hired 09/12/2012. Program Supervisor C's record included approximately 8.25 hours of continuing education training for 2022.	N 277		

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N 277	Continued From page 5 On 09/18/2023 at 2:18 PM, Surveyor conducted an exit conference and shared findings with Administrator A. Administrator A stated Caregiver B and Program Supervisor C transferred from one of the provider's adult family homes (AFH) to this facility in May 2022. Administrator A stated their continuing education reflects the 8-hour requirement in AFH's. Surveyor noted since both employees worked in a CBRF, at least 15-hours of continuing education would need to be completed.	N 277		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure all Individual Service	N 387		

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N 387	Continued From page 6 Plans (ISP) had been signed by the responsible parties. One of 2 ISP's reviewed did not contain the required signatures. Findings include: On 09/14/2023, Surveyor reviewed resident records and identified the following: Resident 2 was admitted 06/03/2022 with diagnoses including intellectual/developmental disability, schizophrenia, and anxiety. Resident 2 had a legal guardian that made decisions on his/her behalf. Resident 2's record contained an ISP dated 07/11/2023. The ISP did not include a signature from Resident 2's guardian. A review of Resident 2's progress notes dated 07/01/2023-09/13/2023 documented Resident 2 going on home visits almost weekly to Guardian F's home. On 09/14/2023 at 10:30 AM, Surveyor interviewed Program Director E. Program Director E confirmed s/he did not have a signed copy of Resident 2's ISP. Surveyor asked why Resident 2's ISP was not signed especially since Resident 2 visited Guardian F frequently. Program Director E stated it's hard to get Guardian F to sign documents. Program Director E stated Resident 2 was going home today and s/he would send a copy with staff for Guardian F to sign.	N 387		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities	N 389		

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N 389	Continued From page 7 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 observation, record review, and interview, the individual service plan (ISP) was not updated for 1 of 2 residents reviewed when there was a change in resident needs and abilities. Resident 1's ISP was not updated when s/he started using bed rails, a floor mat, and displaying behaviors of putting him/herself on the floor and yelling. This is a repeat violation. See statement of deficiency (SOD) F74C11, dated 10/22/2019. Findings include: Resident 1 was admitted 10/22/2001 with diagnoses including intellectual/developmental disability, seizure disorder, cerebral palsy, depression, mood disorder, psychosis, and self-injurious behavior (SIB). Resident 1 had a legal guardian that made decisions on his/her behalf. On 09/14/2023 at 7:45 AM, Surveyor observed	N 389		

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N 389	Continued From page 8 Resident 1's bedroom. Observed attached to Resident 1's bed was a set of 2 quarter bed rails. Observed on the floor next to Resident 1's bed was a fall mat. Surveyor asked Program Supervisor C if Resident 1 used the bed rails. Program Supervisor C stated Resident 1 used the bed rails to assist in getting in/out of bed. Program Supervisor C stated s/he did not know how long the bed rails and fall mat had been used for. Resident 1's progress notes dated 07/01/2023-09/13/2023 documented: "07/22/2023: ...After [Resident 1] was in bed [s/he] started screaming loudly. Staff checked on [him/her] and [s/he] kept saying "hurts", staff gave PRN Acetaminophen, seemed effective. 07/23/2023: ..After [Resident 1] was in bed [s/he] started screaming again but wouldn't answer staff when asked what's wrong. 07/28/2023: ...In bed around 9 some yelling in bed but seemed fine sleeping around 11. 07/30/2023: ...In bed around 9 yelled in [his/her] room for no reason, sleeping around 2. 07/31/2023: [Resident 1] was screaming when staff arrived for shift. Would not tell staff what was wrong. [Resident 1] put [him/herself] on the floor in front of [his/her] recliner. Staff assisted [him/her] off the floor. Ate all of dinner in between crying and screaming. 08/01/2023: [Resident 1] had a shower after breakfast. [S/he] was yelling before lunch ..... [S/he] continued to do this for 20-30 minutes, [s/he] finally calmed down cause [s/he] wanted to sit on the floor .....[S/he] kept wanting to sit on the floor in the living room .....Put [him/herself] on the floor in front of [his/her] chair, would only allow staff to get [him/her] up for dinner. After dinner staff toileted [him/her] and changed [him/her] and assisted [him/her] into recliner. [Resident 1]	N 389		

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proceeded to again put [him/herself] on the floor in front of [his/her] chair, would only let staff assist [him/her] up for snack and bedtime. After staff assisted [him/her] into bed [s/he] proceeded to scream and yell no matter what efforts staff made to make [him/her] more comfortable.
08/02/2023: [Resident 1] put [him/herself] on the floor at the beginning of shift. Only allowed staff to assist [him/her] for dinner. After dinner, staff assisted [Resident 1] into [his/her] recliner, then [Resident 1] put [him/herself] on the floor again and only allowed staff to assist [him/her] up at bedtime.
08/03/2023: [Resident 1] watched movies with [his/her] housemates. [S/he] wants to sit on the floor last few days, [s/he] claims [s/he] feels better on the floor.
08/21/2023: [Resident 1] watched tv and colored, we cleaned, put up new curtains and rearranged [his/her] room, [s/he] ate well, then we went to get [him/her] a mat for the floor hopping it will help with [his/her] bruising when on the floor.
09/09/2023: ...In bed around 1015, [s/he] yelled but seemed fine and would yell when staff left the room sleeping around 1.
09/10/2023: [Resident 1] was up and yelling off and on, [s/he] seemed to be comfortable and asked about pain said no, sleeping around 2am.
09/13/2023: [Resident 1] was up when staff arrived, in bed around 930 watched a movie, in bed so yelling early but only when staff left the room."

Resident 1's ISP dated 07/18/2023 documented: "Describe level of supervision: [Resident 1] has SIB and must be checked periodically to prevent skin issues.
Adaptable equipment needed: Wheelchair.
Behavior challenges which require support interventions (check all that apply): Self harm or

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N 389	Continued From page 10 SIB." The ISP did not address the use of bed rails or fall mat. The ISP did not include interventions to mitigate Resident 1's documented behaviors of putting him/herself to the floor and yelling. On 09/14/2023 at 10:30 AM, Surveyor interviewed Program Director E. Program Director E stated s/he was responsible for updating ISP's. Program Director E stated s/he did not know Resident 1 had the bed rail and floor mat. Program Director E confirmed both interventions were not addressed on Resident 1's ISP. On 09/18/2023 at 2:18 PM, Surveyor conducted an exit conference and shared findings with Administrator A. Surveyor noted after reviewing Resident 1's record, s/he had many documented incidents of putting him/herself on the floor and yelling episodes. Surveyor expressed only SIB was checked on Resident 1's ISP without interventions included. Administrator A acknowledged ISP's should include more information than just checked boxes. Administrator A stated s/he would follow up with Program Director E to add the above information to Resident 1's ISP.	N 389		
N 530	83.47(3) Fire inspection. Fire inspection. The CBRF shall arrange for an annual inspection by the local fire authority or certified fire inspector and shall retain fire inspection reports for 2 years.	N 530		

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N 530	Continued From page 11 This Rule is not met as evidenced by: Based on record review and interview, the provider did not arrange for annual inspection by the local fire authority or certified fire inspector. The facility had not had a fire inspection completed in 2021 and 2022. Findings include: On 09/14/2023, Surveyor reviewed safety records and identified the following: Surveyor was unable to locate the fire inspections for 2021 and 2022. On 09/18/2023 at 2:18 PM, Surveyor conducted an exit conference and shared findings with Administrator A. Administrator A confirmed s/he did not have evidence a fire inspection was completed in 2021 or 2022. Administrator A stated s/he had their business office manager reach out to the local fire department and they noted they only inspect homes with dwellings of 3 units or more. Administrator A stated s/he is familiar with the code as another one of the provider's homes in Beloit had to work with the local fire department. Administrator A stated s/he will have to do more research to meet this requirement.	N 530		
N 666	83.59(7)(a) Emergency egress lighting provided All exit passageways and stairways shall be provided with emergency egress lighting with a stand-by power source. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 5 of 5 emergency egress lightings	N 666		

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N 666	Continued From page 12 were illuminated with a stand-by power source. Findings include: On 09/14/2023, Surveyor toured the facility and observed the following: Surveyor observed 5 wall-mounted battery power egress light fixtures were not in working order. Five of 5 emergency egress lightings did not illuminate when tested. On 09/18/2023 at 2:18 PM, Surveyor conducted an exit conference and shared findings with Administrator A. Administrator A acknowledged staff are supposed to check emergency egress lightning when conducting monthly smoke detector checks. Administrator A noted s/he will work on getting the emergency lights in working order.	N 666		