| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0020461 | A. BUILDING: _____ B. WING _____ | R-C 06/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ADAVA CARE OF GLENDALE I | 7325 N PORT WASHINGTON ROAD BAYSIDE, WI 53217 |

| (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<br><br>On 06/30/2025, Surveyor completed a verification visit and 1 complaint investigation at Adava Care of Glendale I. As a result, 4 of the previous deficiencies were corrected,1 new deficiency was identified. One complaint was substantiated.<br><br>Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed.<br><br>Census: 9 | {N 000} | | |
| N 358 | 83.32(3)(n) Rights of Residents: Safe environment<br><br>In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews, the provider did not ensure 1 of 1 resident (Resident 7) was safeguarded from environmental hazardous conditions. Resident 7 resided in his/her room which contained wet carpet in the hallway and standing water on the bathroom floor due to an overflowing bathroom toilet. Resident 7 resided in the room for 3 days before the issue was resolved. Resident 7 was at significant risk of slipping and falling due to prolonged exposure to hazardous conditions.<br><br>Findings Include: | N 358 | | |

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

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| N 358 | Continued From page 1<br><br>The Department received a complaint on 05/13/2025, stating concerns about physical environment safety. A resident's bathroom contained standing water on the bathroom floor with part of the bedroom carpet being soaked. Action was not taken to keep a resident safe from potentially slipping and falling on the wet floor.<br><br>On 06/30/2025,at approximately 10:45 AM, Surveyor conducted an onsite complaint investigation and reviewed Resident 7's record:<br><br>Resident 7 was admitted to the facility on March 8, 2024, with diagnosis of Alzheimer's disease and orthostatic hypertension.<br><br>Resident 7's current Individual Service Plan, dated 08/12/2024, stated the following:<br>Wanders: Wanders intrusively, is easily redirected.<br>Wandering Assistance: Resident scored 5-9 points. Resident is at Medium risk for wandering and needs staff assistance through regular monitoring.<br>Orientation: Intermittent Confusion. Resident requires staff redirection/ and or re-orientation for their current or past mental and or behavior issues.<br>Psychosocial Issues: Not capable of independent decision making or exhibits bad judgment.<br>Social Profile and Life Enrichment: Needs daily assistance and supervision with consistent redirection in activities and events. Exhibits short attention span.<br><br>On 06/30/2025, at approximately 11:00 AM, Surveyor reviewed the facility maintenance request form dated 04/09/2025. The form indicated Resident 7's toilet seat was replaced. | N 358 | | |

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| N 358 | Continued From page 2<br><br>The form also indicated a request to have Resident 7's bathroom floor replaced.<br><br>On 06/30/2025, at approximately 11:15 AM, Surveyor reviewed email documentation provided by Administrator F. The email document was timestamped with a date of 04/13/2025 at 9:16 PM and April 14, 2025, at 10:29 AM. The email indicated Resident 7's bathroom was soaked along with the carpet in the bedroom from the toilet overflowing when Guardian I arrived at the facility on 04/12/2025 around 2:30 PM and the staff was not aware of when the toilet overflowed and how long it had been overflowing. Guardian I spoke with Administrator F on 04/12/2025 via phone per the email documentation. Administrator F instructed facility staff to plunge the toilet and clean up the area with towels according to the email document. After the toilet was plunged, plastic snack wrappers were found in the toilet. The toilet was described to overflow again on the PM shift on 04/13/2025 at approximately 3:00 PM while Guardian I visited with Resident 7. Per the email documentation the guardian notified Owner B and Regional Director Of Operations H (RDO H) on 04/13/2025 at 9:16 PM via email. On 04/14/2025 per the email documentation the facility had maintenance snake the toilet and a sock was found in Resident 7's toilet on 04/14/2025.<br><br>On 06/30/2025, at approximately 1:15PM, Surveyor interviewed Administrator F, LPN G, and RDO H about Resident 7's toilet overflowing and the safety concerns. Surveyor asked Administrator F how the facility kept Resident 7 safe as the Resident 7's carpet in his/her room was wet and the toilet continued to be clogged for approximately 3 days. Administrator F responded with "Resident 7 was instructed to use another | N 358 | | |

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| N 358 | Continued From page 3<br>bathroom in the room next door as the room next door was empty." Surveyor questioned Resident 7's ability to recall and remember due to his/her diagnosis. Administrator F agreed Resident 7 had difficulty with his/her memory and probably continued to attempt to use the bathroom in his/her room when staff was not around to assist. Surveyor explained the concern of fall risk as Resident 7's ISP indicated s/he was a wanderer with intermittent confusion, and not capable of independent decision making or exhibits bad judgment per the Individual Service Plan. RDO H reported the facility should have taken additional steps to keep Resident 7 safe by having maintenance address the issue sooner. LPN G reported Resident 7 was not capable of following directions without staff cueing and assistance. Although the toilet and floor were replaced, Resident 7 remained in an unsafe environment for 3 days before the issue was resolved. | N 358 | | |