STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017325	A. BUILDING: _____ B. WING _____	R-C 01/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE SENIOR LIVING	**820 BEAR PAW AVE RICE LAKE, WI 54868**

(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 12/28/2023, Surveyor conducted a verification visit at Cambridge Senior Living for Statement of Deficiency (SOD) 9M4F11 and SOD TCA213. Surveyor also conducted a self-report and complaint survey. Data was collected through 01/02/2024. The deficiencies from SOD 9M4F11 and TCA213 were corrected. The complaint was unsubstantiated. The self-report had substantiated findings. Three deficiencies were identified. One of the 3 deficiencies was a repeat violation. See SOD C5DD11, dated 09/04/2020. Census: 42 Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed.	{N 000}		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not immediately notify Resident 1's	N 169		

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

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N 169	Continued From page 1 physician after Resident 1 eloped from the facility. This was a repeat violation. See Statement of Deficiency C5DD11, dated 09/04/2020. Findings include: On 08/18/2023, the Department received a self-report from the provider that Resident 1 eloped from the facility on 08/15/2023. The report indicated the provider received a call from the hospital, at 7:20 p.m., notifying them that Resident 1 was found outside the hospital at approximately 6:55 p.m. On 12/28/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 10/12/2022, with a diagnosis of unspecified dementia. Resident 1 had a legal guardian. Regional Operations Director (ROD) B documented a late entry, dated 08/15/2023, which read: "Resident was outside of facility and brought back by staff [initials] - [s/he] noted [him/her] to be per [his/her] baseline (both cognitive and physical - remembering staff member [name] as familiar to [him/her]), POA (power of attorney) declined medical evaluation. New safety measure in place per building protocol to prevent future instances." On 12/28/2023 at approximately 3:00 p.m., Surveyor interviewed Administrator A and ROD B. Surveyor asked if Resident 1's physician was notified of the elopement. Administrator A was not an employee at the time of this incident. ROD B told Surveyor there was no documentation to indicate Resident 1's physician was notified.	N 169		

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N 389	Continued From page 2	N 389		
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 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 record review and interview, the provider did not re-assess and update Resident 1's individual service plan (ISP) after s/he eloped from the facility. Findings include: On 08/18/2023, the Department received a self-report from the provider that Resident 1 eloped from the facility on 08/15/2023. The report indicated the provider received a call from the hospital, at 7:20 p.m., notifying them that Resident 1 was found outside the hospital at approximately 6:55 p.m. The hospital is located approximately 0.4 miles from the facility. Resident 1 would have crossed State Highway 48 to walk from the facility to the hospital.	N 389		

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N 389	Continued From page 3 On 12/28/2023, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 10/12/2022, with a diagnosis of unspecified dementia. Resident 1 had a legal guardian. Regional Operations Director (ROD) B documented a late entry, dated 08/15/2023, which read: "Resident was outside of facility and brought back by staff [initials] - [s/he] noted [him/her] to be per [his/her] baseline (both cognitive and physical - remembering staff member [name] as familiar to [him/her]), POA (power of attorney) declined medical evaluation. New safety measure in place per building protocol to prevent future instances." Resident 1's ISP, dated 10/12/2023, did not indicate Resident 1 had a history of elopement. On 12/28/2023 at approximately 3:00 p.m., Surveyor interviewed Administrator A and ROD B. Surveyor requested any elopement risk assessments for Resident 1. Administrator A said there were no elopement risk assessments for Resident 1. Administrator A and ROD B explained to Surveyor Resident 1 was never deemed to be a risk for elopement. Surveyor asked if Resident 1's ISP was updated to indicate Resident 1 did have a history of elopement. They both said it was not updated. Surveyor explained that Resident 1 eloping from the facility was a change in Resident 1's condition and Resident 1 should have been re-assessed for his/her elopement risk and Resident 1's ISP should have been updated to reflect this change. Administrator A and ROD B confirmed understanding.	N 389		
Y3100	50.09(1)(f) RESIDENT'S RIGHTS IN CERTAIN FACILITIES	Y3100		

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Y3100	Continued From page 4 (2) The department, in establishing standards for nursing homes and community based residential facilities may establish, by rule, rights in addition to those specified in sub. (1) for residents in such facilities. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure each resident's right to have private, unrestricted communications; and physical and emotional privacy in living arrangements was maintained. This had the potential to effect 42 of the 42 residents that resided in the facility. The facility had multiple electronic video surveillance cameras, including cameras located in 4 of the 4 bistros. Findings include: This provider is licensed to care for up to 68 residents in the client groups of: advanced age, physically disabled, and irreversible dementia/Alzheimer's disease. The facility is 2 floors with the east and west wings mirroring each other on each floor. Each wing has a dining area and a bistro.	Y3100		

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Y3100	Continued From page 5 The Department's position on electronic video monitoring or filming in areas where residents may be seen or heard is viewed as infringing upon a resident's right to privacy and right to a living arrangement that is as homelike as possible. On 08/18/2023, the Department received a self-report that indicated Resident 1 eloped from the facility on 08/15/2023. The report read, in part: "Upon camera review, resident [number] had located the 'exit' button behind front desk and released the door, allowing [Resident 1] to exit building without alarming the door at approximately 6:40 p.m." On 12/28/2023 at approximately 10:30 a.m., Surveyor toured the facility with Administrator A. Surveyor observed cameras at the entrances/exits of the facility, near the administrative offices and conference room and in all 4 bistros located in the facility. The cameras in the bistros were located on the ceiling facing the cooking area. (Photo 1). There were no doors or signs to indicate this area was not for residents to access. Administrator A told Surveyor they do have cooking activities in the bistros. The provider did not ensure each resident's right to privacy was maintained when they installed electronic surveillance cameras in areas where residents may be seen or heard.	Y3100		