STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008581	A. BUILDING: _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINNIC FALLS ALCOHOL-DRUG SERV	900 SOUTH ORANGE ST RIVER FALLS, WI 54022

(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 07/15/2024, Surveyor conducted an abbreviated survey at Kinnic Falls Alcohol Drug Servs Inc. Data collection continued through 07/18/2024. Four deficiencies were identified. Census: 35	N 000		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure caregiver background checks (CBC) were completed for 2 of 4 employees sampled. Findings include: According to The Wisconsin Caregiver Program Manual (P-00038), Wis. Stat. ch. 50, and Wis.	N 219		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008581	A. BUILDING: _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINNIC FALLS ALCOHOL-DRUG SERV	900 SOUTH ORANGE ST RIVER FALLS, WI 54022

(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 219	Continued From page 1 Admin. Code ch. 12, a complete CBC, at minimum, consists of: 1) A completed DHS form F-82064, Background Information Disclosure (BID). 2) A response from the Department of Justice (DOJ). 3) A "Response to Caregiver Background Check" letter from the Department of Health Services (DHS). The provider is licensed to care for 52 adults in the client groups advanced aged, alcohol/drug dependent, traumatic brain injury and correctional clients. On 07/15/2024, Surveyor requested to review a sample of 4 employee records. Counselor B had a hire date of 05/02/2023. The record did not contain the caregiver background check. Unit Tech (UT) E had a hire date of 01/04/2024. The record did not contain a DOJ report or "Response to Caregiver Background Check" letter from DHS. On 07/15/2024, Surveyor received an email from Associate Finance Director (AFD) F with background checks attached for Counselor B and UT E. Both background checks received for Counselor B and UT E were dated 07/15/2024, the date of survey. The provider did not ensure a CBC was completed for 2 of 4 employees at the time of hire.	N 219		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008581	A. BUILDING: _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINNIC FALLS ALCOHOL-DRUG SERV	900 SOUTH ORANGE ST RIVER FALLS, WI 54022

(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 220	Continued From page 2	N 220		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 4 employees were screened for communicable disease, including tuberculosis (TB), within 90 days before the start of employment. Findings include: On 07/15/2024, Surveyor reviewed the following sample of 4 employee records: Counselor B had a hire date of 05/02/2023. The record did not contain documentation to show Counselor B had been screened for communicable disease, including TB. Counselor C had a hire date of 10/03/2016. The record did not contain documentation to show Counselor C had been screened for communicable disease.	N 220		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008581	A. BUILDING: _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINNIC FALLS ALCOHOL-DRUG SERV	900 SOUTH ORANGE ST RIVER FALLS, WI 54022

(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 220	Continued From page 3 Counselor D had a hire date of 06/01/2021. The record did not contain documentation to show Counselor D had been screened for communicable disease. Unit Tech (UT) E had a hire date of 01/04/2024. The record did not contain documentation to show UT E had been screened for communicable disease. On 07/16/2024 at 10:08 AM, Surveyor received an email from Associate Finance Director (AFD) F which read, in part: "The TB tests will be completed. With Covid [sic] Pierce County Human Services were not doing them at that time and I think that just fell through the cracks to get them done. There are only a few employees who need to have that done, and we have a plan in place to get that taken care of." On 07/18/2024, AFD F emailed Surveyor the following TB tests s/he was able to locate: Counselor D had a negative TB test, dated 04/25/2013; approximately 8 years prior to hire date. Counselor C had a negative TB test, dated 01/06/2017, approximately 3 months after hire date. UT E had a negative TB test, dated 09/12/2023, approximately 114 days prior to hire date. Employees were not screened within 90 days before the start of employment. The communicable disease screening questions, and signature lines on the documentation received from AFD F indicating the employee had	N 220		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008581	A. BUILDING: _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINNIC FALLS ALCOHOL-DRUG SERV	900 SOUTH ORANGE ST RIVER FALLS, WI 54022

(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 220	Continued From page 4 been screened for communicable disease were left blank, or were not available, for 4 of 4 employee records reviewed.	N 220		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 4 employees obtained all department approved training as required.	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008581	A. BUILDING: _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINNIC FALLS ALCOHOL-DRUG SERV	900 SOUTH ORANGE ST RIVER FALLS, WI 54022

(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 239	Continued From page 5 Counselor B did not have training in fire safety within 90 days after starting employment. Counselor B did not have training in first aid and choking within 90 days after starting employment. Counselor B, who had responsibilities that would create exposure to blood, body fluids or other moist body substances, did not have training in standard precautions prior to assuming these duties. Findings include: On 07/15/2024, Surveyor conducted a review of 4 employees to verify compliance with department approved training requirements. Surveyor requested training records from Associate Finance Director (AFD) F for Counselor B. FIRE SAFETY The record for Counselor B, hired 05/02/2023, did not contain evidence of training or evidence of meeting an exemption for fire safety. On 07/15/2024, at approximately 12:30 PM, Surveyor interviewed Support Services Administrator (SSA) G. SSA G stated s/he would follow up with AFD F when s/he returned from his/her meeting. On 07/15/2024, Surveyor verified Counselor B was not on the Community-Based Care and Treatment training registry for fire safety. FIRST AID AND CHOKING The record for Counselor B, hired 05/02/2023, did not contain evidence of training or evidence of meeting an exemption for first aid and choking.	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008581	A. BUILDING: _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINNIC FALLS ALCOHOL-DRUG SERV	900 SOUTH ORANGE ST RIVER FALLS, WI 54022

(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 239	Continued From page 6 On 07/15/2024, at approximately 12:30 PM, Surveyor interviewed SSA G. SSA G stated s/he would follow up with AFD F when s/he returned from his/her meeting. On 07/15/2024, Surveyor verified Counselor B was not on the Community-Based Care and Treatment training registry for first aid and choking. STANDARD PRECAUTIONS The record for Counselor B, hired 05/02/2023, did not contain evidence of training or evidence of meeting an exemption for standard precautions. On 07/15/2024 at approximately 12:30 PM, Surveyor interviewed SSA G. SSA G stated s/he would follow up with AFD F when s/he returned from his/her meeting. OD B stated staff do not provide assistance with personal cares but would have the potential to be exposed to blood, body fluids, or other moist body substances. On 07/15/2024, Surveyor verified Counselor B was not on the Community-Based Care and Treatment training registry for standard precautions. On 07/17/2024 at 10:55 AM, Surveyor interviewed AFD F via phone. AFD F stated s/he "overlooked" Counselor B's training upon hire since Counselor B was in college at the time of hire.	N 239		
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	N 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008581	A. BUILDING: _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINNIC FALLS ALCOHOL-DRUG SERV	900 SOUTH ORANGE ST RIVER FALLS, WI 54022

(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 530	Continued From page 7 inspection reports for 2 years. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an annual fire inspection was conducted by the local fire authority or certified fire inspector in 2023. Findings include: On 07/15/2024, Surveyor requested annual fire inspection reports conducted in 2022 and 2023. Operations Director (OD) A provided Surveyor with a report with an inspection date of 09/28/2022. The inspection report showed five violations were identified by the local fire authority on this date. Surveyor requested documentation of a follow-up visit and asked if an inspection had been completed for 2023. OD A provided Surveyor with an email from the local fire chief, dated 07/15/2024, which read, "During the last half of 2023, the [city name] fire department saw a surprise turnover of its fire inspectors. AS [sic] a result, many inspections for the last half of the year were not completed as is the case for [provider address]. Currently, we have eight new inspectors that will be completing their training in the next two weeks ad [sic] will be working to get caught up in our past-due inspections." OD A informed Surveyor the email provided explained why the inspection was not completed for 2023 and stated they would get something	N 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008581	A. BUILDING: _____ B. WING _____	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINNIC FALLS ALCOHOL-DRUG SERV	900 SOUTH ORANGE ST RIVER FALLS, WI 54022

(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 530	Continued From page 8 scheduled for 2024 as soon as possible.	N 530		