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MILESTONE SENIOR LIVING RENEE CBRF	5510 RENEE DR EAU CLAIRE, WI 54703

(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 08/22/2023, Surveyors conducted a standard survey and five complaint investigations at Milestone Senior Living Renee. Data collection continued through 09/05/2023. Three of 5 complaints were substantiated. Eighteen deficiencies were identified. Nine of 18 deficiencies were repeat violations. See Statement of Deficiency (SOD) 732R11, dated 12/19/2019, ZWVC11, dated 06/20/2019, 9HCZ13, dated 04/29/2019, YPZH11, dated 11/27/2018, 9HCZ11, dated 10/25/2018, and NYG911, dated 07/16/2018. Census: 18	N 000		
N 187	83.13(2)(d) Dated menus retained for 60 days. Dated menus shall be retained for 60 days. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure dated menus were retained for 60 days from 08/22/2023. Findings include: On 08/22/2023, Surveyor requested the provider's menus for the past 60 days. At 8:35 AM, Surveyor interviewed Cook D. Cook D stated s/he was the culinary director for the facility. Cook D described his/her training as, "I got handed a computer and told to make a menu." Cook D said there were no menus prior to the ones s/he created. Surveyor requested the menus Cook D created and Cook D stated s/he	N 187		

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N 187	Continued From page 1 was directed by Director A to not give them to Surveyor. 11:22 AM, Surveyor interviewed Cook D. Cook D stated Director A asked Cook D to send the menus for 3 months. Cook D said s/he told Director A that there were no menus prior to the ones Cook D created around July 15th. Cook D said, "[Director A] wanted me to say I used these the last 3 months. I said I'm not comfortable with that." Cook D explained that s/he created a 5-week rotation menu and started implementing it around July 15th. Cook D stated s/he believed s/he started with the week 3 menu. Cook D said s/he was not aware s/he needed to have dated menus, so s/he put dates on them today per Director A's request, but s/he refused to backdate the menus before they were created. Surveyor reviewed the menus Cook D provided Director A. The 5-week rotation was dated as follows: - Week 1, 08/13/2023-08/19/2023 - Week 2, 08/20/2023-08/26/2023 - Week 3, 08/27/2023-09/02/2023 - Week 4, 09/03/2023-09/09/2023 - Week 5, 09/10/2023-09/16/2023 Cross reference: Y3098 Wis. Stat. ch. 50.07 Prohibited Acts	N 187		
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.	N 196		

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N 196	Continued From page 2	N 196		

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the licensee did not ensure the community-based residential facility (CBRF) and operation complied with all laws.

This is a repeat deficiency. See Statement of Deficiency (SOD) 9HCZ13, dated 04/29/2019.

Findings include:

The provider was licensed in 2018 to care for 26 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. Since licensure, the Department has received 11 complaints; seven have been substantiated. The provider has had nine surveys that resulted in enforcement action and a total of 32 deficiencies.

In June and July 2023, the Department received 5 complaints related to the provider's administration, operation, and resident services. Three of 5 complaints were substantiated and the following concerns were identified:
- The administrator was not present at the facility and the designated staff in charge had not completed required training.
- Caregiver background checks were not completed for all staff sampled.
- Staff did not have the skills or competency to fulfill their job responsibilities.
- Staff did not complete required training.
- Residents were not screened for communicable disease, including tuberculosis, as required.
- Resident individual service plans (ISPs) were not implemented as written.
- Resident ISPs were not updated upon changes in condition.
- Department-approved resident satisfaction surveys were not provided to residents and/or

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N 196	Continued From page 3	N 196		

their legal representatives.
- Staff were not provided in sufficient numbers to meet resident needs.
- Staff schedules were not maintained.
- Menus were not posted or made available to residents.
- Menus were not dated and retained for 60 days and deviations were not recorded.
- Hot foods were not held at a safe holding temperature.
- Evacuation drills were not completed as required.
- Records were withheld, altered, and not provided timely to the Department during the survey process.

On 08/22/2023, from 7:50 AM to 4:50 PM, Surveyors were on site at the facility. At 7:50 AM, Surveyor entered the facility and asked to see the administrator. Surveyor was informed Director A was not available and on vacation. Director A did not match the listed administrator on record; Administrator H was listed. Health Care Coordinator (HCC) B informed Surveyor that Director A was designated to be in charge at the facility and if Director A was not available, then s/he (HCC B) was designated to be in charge. HCC B informed Surveyor that Administrator H's position and role may be changing within the company but did not know in what capacity his/her role would be changing. HCC B stated Director A had been employed approximately one year and was responsible for overseeing the daily operations of the facility.

Surveyor requested documentation to verify facility compliance from Assistant Administrator (AA) C, Caregiver E (who stated s/he was a lead caregiver and was working in the office at the time of survey), HCC B, and Cook D.

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N 196	Continued From page 4 Director A contacted the employees listed above throughout the course of the survey and instructed staff to send him/her documents to review prior to handing over documentation to Surveyor to review. At 8:35 AM, Surveyor interviewed Cook D. Cook D stated s/he had been employed since July and had only witnessed Director A in the building "3 or 4 times" since s/he began employment. Cook D stated s/he was full-time and typically worked daytime hours. Cook D was at the building when Surveyor arrived at 7:50 AM and was still working at 4:50 PM when Surveyor left the building on 08/22/2023. At 9:50 AM, Surveyor interviewed Maintenance Director (MD) G and asked if Director A was present in the building on a daily basis. MD G stated, "No, I text [him/her]. We keep in touch that way." MD G stated s/he assumed Director A worked from home a lot and stated s/he did cover shifts from time to time on the weekends and evenings. Surveyor asked MD G if s/he was aware who the listed administrator was. MD G stated, "I have no idea who is above [Director A]." On 09/05/2023 at 11:00 AM, Surveyor conducted an exit interview with the provider's regional team. The regional team consisted of Administrator H, Regional Nurse (RN) J, RN W, RD K, and Compliance Manager (CM) L. Director A was not available to attend the conference call. At approximately 11:45 AM, Administrator H explained his/her role as "I was the one that hired the current director... My license is still there until someone is qualified to take over the license... I have not been in the building for a period of time because my area had changed. We [Director A	N 196		

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N 196	Continued From page 5 and Administrator H] have meetings at least weekly... any issues that needed to be addressed [Director A] was bringing to my attention and we would work through them." Surveyor discussed concern that some staff did not know who Administrator H was. CM L stated Administrator H's contact information was posted in the facility. Surveyor asked how often the administrator or designee should be on site. Administrator H stated that the director should be on site a minimum of 5 days per week. "There was a point in time when it was brought to my attention that [Director A] was not in there consistently. [S/he] and I had this discussion and expectations were made very clear." Administrator H stated s/he believed the issue was resolved. The provider has been found to be noncompliant with 83.15(3)(a) Administrator Shall Supervise Daily Operation 3 times and failed to implement a system to ensure an administrator or designee supervised the daily operation. See Statement of Deficiencies (SOD) 732R11, dated 12/19/2019; 9HCZ13, dated 04/29/2019; 9HCZ12, dated 02/11/2019. Cross references (regulations identified with an asterisk (*) are repeat violations): N0187 DHS 83.13(2)(d) Dated Menus Retained For 60 Days N0215 DHS 83.15(3)(b) Administrator Responsible For Staff Training N0216 DHS 83.15(3)(c) Qualified Staff Designated As In Charge N0219 DHS 83.17(1) Licensee Conduct Caregiver Background Check N0230 DHS 83.19 Orientation* N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses*	N 196		

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N 196	Continued From page 6 N0243 DHS 83.21(1)-(3) All Employee Training* N0302 DHS 83.28(4)(a) Resident Health Screening And Documentation N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan* N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0392 DHS 83.35(4) Resident Satisfaction Evaluation N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs* N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule* N0450 DHS 83.41(2)(c) Nutrition: Menus* N0452 DHS 83.41(3)(b) Food Safety* N0525 DHS 83.47(2)(d) Fire Drills N0526 DHS 83.47(2)(e) Other Evacuation Drills Y3098 Wis. Stat. ch. 50.07 Prohibited Acts Z0012 Wis. Stat. ch 50.065(2)(bm) Out Of State Background Checks	N 196		
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.	N 219		

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N 219	Continued From page 7	N 219		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure a caregiver background check (CBC) was completed for 2 of 5 employees sampled. Director A and Caregiver F did not have a CBC on file.

Findings include:

According to The Wisconsin Caregiver Program Manual (P-00038), Wis. Stat. ch. 50, and Wis. 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 Service, also referred to as the Integrated Background Information System (IBIS).

On 08/22/2023, Surveyor reviewed employee records.

Director A was hired on 09/12/2022. His/her record did not include a BID, DOJ, and IBIS.

Caregiver F was hired on 06/09/2023. His/her record included a BID but did not include a DOJ or IBIS.

At 4:29 PM, Surveyor interviewed Health Care Coordinator (HCC) B. HCC B stated Director A was responsible for hiring new employees. Director A was on paid time off so HCC B made a list of the items Surveyor needed to complete the survey. Surveyor discussed needing Director A's

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N 219	Continued From page 8 CBC and Caregiver F's DOJ and IBIS. On 08/23/2023 at 2:55 PM, Surveyor interviewed Director A. Director A stated s/he had information to send Surveyor for review. As of 09/05/2023, Surveyor did not receive additional CBC documentation for Director A or Caregiver F. On 09/05/2023 from 11:00 AM to 1:00 PM, Surveyor interviewed Administrator H, Regional Nurse (RN) J, Regional Director (RD) K, Compliance Manager (CM) L, and RN W. At approximately 11:30 AM, Administrator H stated s/he was responsible for hiring Director A. Surveyor discussed concern that Director A and Caregiver F did not have a completed CBC on file. At approximately 11:40 AM, CM L asked if they could still send information to Surveyor. Surveyor stated s/he would accept information within 2 hours after the call. As of 09/06/2023, Surveyor did not receive additional CBC documentation for Director A or Caregiver F.	N 219		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and	N 230		

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N 230	Continued From page 9 disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not provide 4 out of 6 employees reviewed, with orientation training to include job responsibilities, prevention and reporting of resident abuse, neglect and misappropriation of resident property, information regarding assessed needs and individual services for each resident for whom the employee is responsible, emergency and disaster plan and evacuation procedures, CBRF (community based residential facility) policies and procedures, and recognizing and responding to resident changes of condition, prior to an employee performing any job duties. This is a repeat deficiency. See Statement of Deficiency (SOD) 732R11, dated 12/19/2019. Findings include: On 08/22/2023, Surveyor requested 5 employee records, including: Director A, Cook D, Caregiver F, and Caregiver I. The employee roster identified the following dates of hire for the employees: Director A - 09/12/2022 Cook D - 07/05/2023 Caregiver F - 06/09/2023 Caregiver I - 08/03/2022 Surveyor could not locate orientation training for Director A, Cook D, and Caregiver F. Caregiver	N 230		

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N 230	Continued From page 10	N 230		

I's new employee checklist included Caregiver I's initials by each item but did not include the trainer's initials. Director A signed this checklist on 03/30/2023, which was approximately 8 months after his/her date of hire.

On 08/22/2023 at 4:45 PM, Surveyor interviewed Health Care Coordinator (HCC) B and requested documentation not yet received, which included: employee orientation and onboarding.

On 08/23/2023 at approximately 9:34 AM, Surveyor interviewed Cook D via phone and asked if s/he had any training related to his/her assigned job duties. Cook D stated the only training s/he received was how to do a schedule on their system. Cook D stated s/he had not done any online training or received any training since s/he began employment on 07/05/2023.

On 08/23/2023 at approximately 3:00 p.m., Surveyor interviewed Director A, HCC B, and Regional Nurse (RN) J. Director A said s/he would be sending the new employee orientation checklist. S/he said it was a general checklist and they did not maintain individual checklists for each employee.

On 08/23/2023, Director A emailed additional training information. Surveyor did not receive evidence that Director A, Cook D, Caregiver I or Caregiver F completed orientation training prior to assuming job responsibilities.

On 09/05/2023, from approximately 11:00 a.m. - 1:00 p.m., surveyors conducted an exit interview with the provider's regional team. The regional team consisted of: RN J, Regional Director (RD) K, Compliance Manager (CM) L, RN W, and Administrator H. The team identified that Director

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N 230	Continued From page 11 A, HCC B, and Administrator H were not present in the facility at that time. Surveyor asked who the qualified resident care staff was designated as in charge in the facility at that time. RD K told Surveyor it was Administrative Assistant (AA) C. Surveyor requested to review AA C's training to ensure s/he was a qualified to be designated as in charge. RN J stated Director A and AA C were responsible for new employee training. On 09/05/2023, Surveyor reviewed AA C's employee training. AA C's date of hire was 07/27/2023. AA C's training did not include documentation of employee orientation. The provider did not ensure each employee received new employee orientation prior to performing any job duties. Cross references: N0215 DHS 83.15(3)(b) Administrator Responsible For Staff Training N0216 DHS 83.15(3)(c) Qualified Staff Designated As In Charge	N 230		
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	N 239		

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N 239	Continued From page 12 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 2 of 5 employees obtained all department-approved training as required. Director A did not have training in fire safety within 90 days of hire. Cook D, 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. This requirement is being cited for the third time. See Statement of Deficiency (SOD) 9HCZ11, dated 10/25/2018 and SOD 732R11, dated 12/19/2019. Findings include: On 08/22/2023, Surveyor conducted a review of 5 employees to verify compliance with	N 239		

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department-approved training requirements. Surveyor requested training records from Health Care Coordinator (HCC) B.

The record for Director A, hired 09/12/2022, did not contain evidence of training or evidence of meeting an exemption for fire safety.

The record for Cook D, hired 07/05/2023, did not contain evidence of training or evidence of meeting an exemption for standard precautions. Cook D's job description and hepatitis B vaccination forms, signed on 06/19/2023, indicated Cook D had responsibilities that would create exposure to blood, body fluids, or other moist body substances.

On 08/22/2023, Surveyor verified Cook D was not on the Community-Based Care and Treatment training registry for standard precautions. Director A was not on the training registry for fire safety.

On 08/22/2023 at 4:45 PM, Surveyor interviewed HCC B and requested additional documentation, including Cook D's standard precautions training and Director A's fire safety training.

On 08/23/2023 at approximately 9:34 AM, Surveyor interviewed Cook D via phone and asked if s/he had any training. The only training Cook D stated s/he received was how to do a schedule on their system. Cook D stated s/he had not done any online training or received any training since s/he began employment on 07/05/2023.

As of 08/31/2023, Surveyor did not receive additional department-approved training documentation for Cook D or Director A.

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MILESTONE SENIOR LIVING RENEE CBRF	5510 RENEE DR EAU CLAIRE, WI 54703

(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 243	Continued From page 14	N 243		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise 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	N 243		

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N 243	Continued From page 15 completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 5 employees sampled completed all-employee training within 90 days of hire. Caregiver I did not complete resident rights, client group, or challenging behavior training. This is a repeat violation. See Statement of Deficiency (SOD) 732R11, dated 12/19/2019. Findings include: The provider is licensed to care for 26 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. On 08/22/2023, Surveyor reviewed employee training records. Caregiver I was hired on 08/03/2022. His/her record did not include evidence of training or a training exemption for the following topics: resident rights, client group, or challenging behavior. Surveyor reviewed the Wisconsin nurse aide registry and did not find Caregiver I on the registry. On 08/23/2023 at approximately 3:00 PM, Surveyor interviewed Director A, Health Care Coordinator (HCC) B, and Regional Nurse (RN)	N 243		

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N 243	Continued From page 16 J. Director A said s/he would be sending requested training documentation. On 08/23/2023, Director A emailed additional training information. The additional information included Caregiver I's employee orientation form. Caregiver I marked that s/he completed the online training portion of the orientation, but there was no documentation to indicate s/he completed this.	N 243		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were screened for tuberculosis (TB) in accordance with the Centers for Disease Control and Prevention (CDC) standards.	N 302		

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N 302	Continued From page 17 Resident 1, Resident 2, and Resident 4 did not have a TB test. Findings include: The CDC states: "Certain people should be tested for TB infection because they are at higher risk for being infected with TB bacteria, including: ... People who live or work in high-risk setting (for example: correctional facilities, long-term care facilities or nursing homes, and homeless shelters) ..." (Retrieved on 08/31/2023 from: https://www.cdc.gov/tb/topic/testing/whobetested.htm) According to the Wisconsin Tuberculosis Program publication P-02382A Tuberculosis Screening and Testing: Residents of Care Facilities (retrieved from: https://www.dhs.wisconsin.gov/publications), screening for the presence of communicable disease, including TB, includes the following three steps: 1) TB risk assessment 2) Symptom evaluation 3) TB testing..."Perform baseline testing for all residents without documented evidence of prior LTBI [latent TB infection] or TB disease.... If TST [tuberculin skin test] is used as the baseline testing, 2-step testing is recommended for residents who have not had TST testing previously or have only had one negative TST test greater than 12 months ago. If 2 or more TST tests have been previously performed, all results are negative, and documentation of results is available, a one-step TST may be performed before admission." This provider is licensed to care for up to 26	N 302		

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residents in the client groups of advanced age and irreversible dementia/Alzheimer's disease.

On 08/28/2023, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the facility on 02/15/2023. On 01/31/2023, Health Care Coordinator (HCC) B documented a TB risk assessment and symptom evaluation for Resident 1. Resident 1's physician plan of care, signed 02/02/2023, indicated Resident 1 was free of TB and communicable disease. The physician plan of care form included a section for a 2-step TB test. This was left blank. The form also included results of a chest x-ray. "None" was documented. Surveyor did not locate a TB test in Resident 1's record.

Resident 2 was admitted to the facility on 09/18/2022. On 09/14/2022, HCC B documented a TB risk assessment and symptom evaluation for Resident 2. Resident 2's physician plan of care, signed 09/13/2021, indicated Resident 2 was free of TB and communicable disease. The physician plan of care form included a section for a 2-step TB test, which was left blank.

Resident 4 was admitted to the facility on 08/12/2021. On 08/12/2021, HCC B documented a TB risk assessment and symptom evaluation for Resident 4. Resident 4's physician plan of care, signed 08/06/2021, indicated Resident 4 was free of TB and communicable disease. The physician plan of care form included a section for a 2-step TB test, which was left blank.

On 08/30/2023, at approximately 11:00 a.m., Surveyor interviewed HCC B. HCC B told Surveyor that if the physician checked the

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N 302	Continued From page 19 resident was free of communicable diseases, including TB, s/he completed the risk assessment and symptom evaluation and did not test for TB. Surveyor asked HCC B if any of the residents admitted in the last year were tested for TB. HCC B confirmed s/he only tested 1 resident because their physician did not document the resident were free of TB on the physician plan of care.	N 302		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure staff implemented the individual service plan (ISP) for 3 residents reviewed. Resident 5 was identified as having a risk of choking and was left unsupervised to eat breakfast in his/her bed. Resident 2 and 6 did not receive interventions related to their identified choking risks. This is a repeat deficiency. See Statement of Deficiency (SOD) YPZH11, dated 11/27/2018. Findings include: The provider is licensed to care for 26 residents in the client groups advanced aged and irreversible dementia/Alzheimer's disease. In June and July, the Department received concerns related to resident care and dietary	N 388		

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N 388	Continued From page 20 services. RESIDENT 5 On 08/22/2023 at approximately 8:30 a.m., Surveyor observed a staff member bring breakfast to Resident 5's room. Surveyor entered Resident 5's room. Resident 5 was sitting upright in bed eating breakfast. There were no staff members in his/her room and his/her bed was not visible from the doorway. Staff would not be able to observe Resident 5 eating in bed unless they entered his/her room. At approximately 8:35 a.m., Surveyor interviewed Caregiver I. Surveyor asked if Resident 5 always ate in his/her room. Caregiver I said Resident 5 did not want to get up for the day. At 9:06 a.m., Surveyor entered and observed Resident 5 eating his/her breakfast. Surveyor asked Resident 5 if s/he always ate breakfast in bed. Resident 5 told Surveyor that sometimes s/he ate in bed and sometimes s/he ate at the table. On 08/28/2023, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the facility on 05/31/2018. Resident 5 had a diagnosis of dysphasia, which is difficulty with swallowing. In 2021, Resident 5 was diagnosed with pneumonitis due to inhalation of food and vomit. Pneumonitis is inflammation of the lungs. Resident 5's ISP, dated 05/12/2023, indicated Resident 5 was at risk for choking. The interventions included: "Encourage to eat in an upright position, to eat slowly, and to chew each bite thoroughly before attempting to swallow ...	N 388		

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N 388	Continued From page 21 Invite, encourage and assist to dining area for meals ... Observe and report to Nurse [sic]: choking, coughing, drooling, holding food in side of mouth, making repeated unsuccessful attempts to swallow food, refusing to eat, or appearing concerned during meals ... Provide a calm, pleasant setting at meal times with adequate time for dining. Encourage socialization and interaction with table mates during meals ... Provide and encourage diet as ordered. [Resident 5] to be in broda [sic] chair and in dining room for all meals. General no added salt & thin liquids, cut up all meats & assist as needed. Notify the nurse if any chewing/swallowing problems are noted. Was noted by hospice to be refusing meals with different diet. POA (power of attorney) was educated on what could happen by having a regular diet and was OK d/t (due to) [s/he] is noted to be eating more with diet change ... Staff education provided as required for choking risk ... Stay [sic] to supervise during meals so that you are available to assist as needed." Staff did not ensure Resident 5 was seated upright in his/her Broda chair. Staff did not ensure Resident 5 ate his/her breakfast in the dining room and did not supervise Resident 5 while s/he ate breakfast. RESIDENT 2 On 08/22/2023 at 8:09 a.m., Surveyor interviewed Caregiver M. Caregiver M discussed the residents' dietary needs and referred Surveyor to a sheet hanging in the kitchen that listed each resident's dietary needs. The sheet included instructions for Resident 2 that read, "CUT UP [HIS/HER] FOOD!" At approximately 8:30 a.m., Surveyor observed Resident 2 eating his/her breakfast of fried egg,	N 388		

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sausage patty, and pancakes. Resident 2's egg and sausage patty were not cut up. The pancake on Resident 2's plate appeared to be dry and was ripped into chunks about 1-inch x 1-inch in size.

From approximately 12:10 to 12:30 p.m., Surveyor observed lunch. The meal consisted of chopped salad, mashed potatoes, and Swiss steak with tomatoes. Resident 2's meat was not cut up and s/he only ate his/her mashed potatoes. Resident 2 appeared to have a difficult time swallowing the potatoes as s/he made facial grimaces and stretched his/her neck as s/he swallowed. Surveyor observed Resident 2 pound his/her fist to his/her chest as s/he attempted to swallow. Resident 2 was positioned in the dining room so s/he was not facing staff. Staff appeared not to notice Resident 2 was having difficulty eating his/her food.

At approximately 12:30 p.m., Surveyor requested a test plate. The meat was in large, thinly sliced, sections and was stringy, making it difficult to chew, pull apart, or cut with a fork. The mashed potatoes had large (about 1-inch)chunks.

On 08/28/2023, Surveyor reviewed Resident 2's record.

Resident 2 was admitted to the facility on 09/18/2022. His/her ISP, dated 12/22/2022, read, "Has a risk of choking related to diagnosis and/or other
symptoms...Interventions/Tasks...Assistance with cutting up meats... Observe and report any of the following to the nurse: choking, coughing, drooling, holding food in side of mouth and not swallowing, making repeated unsuccessful attempts to swallow food, refusing to eat, or appearing concerned during meals."

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N 388	Continued From page 23 RESIDENT 6 On 08/22/2023 at 8:09 a.m., Surveyor reviewed the resident dietary needs sheet hanging in the kitchen. The sheet included instructions for Resident 6 that read, "Gravy to meat." On 08/22/2023 at 12:17 p.m., Surveyor observed Resident 6 eating lunch in his/her room with the assistance of Family Member (FM) Y. FM Y stated s/he visited daily during meals to ensure Resident 6 got assistance. FM Y said, "I always bring a knife with... the meat is usually not cut up or it is stringy." Surveyor observed FM Y pick up Resident 6's meat (Swiss steak) with a fork. The meat was stringy. Resident 6's plate did not have any gravy on it. FM Y said s/he worried Resident 6 would choke on the meat if s/he was not there to cut it up for him/her. FM Y stated, "There's such a turnover [in staff] that they don't know the residents." On 08/31/2023, Surveyor reviewed Resident 6's ISP. The ISP, dated 03/16/2023, indicated Resident 6 was a choking risk. Interventions included: "Eats in dining room. Staff to encourage/cueing [sic] and assist as needed with eating... DX [diagnosis] of Dysphasia. Is on a chopped texture diet & thin liquids. Staff to monitor for increased s/sx [sign/symptoms] of difficulty swallowing." On 09/05/2023 at 11:00 a.m., Surveyor conducted an exit interview with the provider's regional team. The regional team consisted of Administrator H, Regional Nurse (RN) J, RN W, RD K, and Compliance Manager (CM) L. Director A and the facility nurse, Health Care Coordinator (HCC) B,	N 388		

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N 388	Continued From page 24 were not available to attend the conference call. RN W stated HCC B was responsible for ensuring resident dietary needs were met. Surveyor asked for clarification of Resident 6's order for a chopped texture diet. RN J stated, "I don't know if I've ever heard that term... I assume it to be food not pureed but chopped into smaller pieces." RN W stated, "That is a weird one.. my interpretation is cut up." Surveyor discussed concern that staff would not know what chopped texture diet was. RN J responded, "Right. Exactly. I'm not sure what [HCC B] meant by that." On 09/05/2023 at 2:42 p.m., Surveyor received an email from RN J indicating a chopped texture diet would be equivalent to mechanical soft.	N 388		
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 observation and interview, the provider	N 389		

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did not ensure the individual service plan (ISP) for 1 resident sampled was updated upon changes in condition. Resident 4's need for dietary assistance was not updated to reflect his/her current needs.

Findings include:

On 08/22/2023 at approximately 8:30 AM and at 12:20 PM, Surveyor observed Resident 4 receive feeding assistance from staff.

On 08/28/2023, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 08/12/2021 with diagnoses that included Parkinson's disease, Alzheimer's disease, and Steele-Richardson-Olszewski syndrome. According to Mayo Health Systems, "Steele-Richardson-Olszewski syndrome is a rare disease that results in serious problems with walking, balance and eye movements, and later with swallowing. Symptoms are caused by a deterioration of cells in your brain that control body movement, coordination, thinking, and other important functions." (Source: https://www.mayoclinic.org/diseases-conditions/progressive-supranuclear-palsy/symptoms-causes/syc-20355659. Retrieved 09/05/2023).

Resident 4's ISP was updated on 06/13/2023, the same day Resident 4 was admitted to hospice. The ISP read, "Is independent with meals and eating and drinking."

The provider's last documented comprehensive assessment, dated 06/13/2023, was consistent with Resident 4's ISP.

Resident 4's record included a hospice assessment, dated 08/10/2023, that read, "[S/he]

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N 389	Continued From page 26 is on hospice services for progressive supranuclear ophthalmoplegia. [S/he] requires assistance with bathing, dressing, grooming, transfers, toileting and eating. [S/he] has a poor appetite and significant weight loss."	N 389		
N 392	83.35(4) Resident satisfaction evaluation. Satisfaction evaluation. At least annually, the CBRF shall provide the resident and the resident ' s legal representative the opportunity to complete an evaluation of the resident ' s level of satisfaction with the CBRF ' s services. The evaluation shall be completed on either a department form or a form developed by the CBRF and approved by the department. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident and resident's legal representative were provided the opportunity to complete an evaluation of the resident's level of satisfaction with the community based residential facility's (CBRF) services on either a Department form or a form developed by the CBRF and approved by the Department. Findings include: On 08/31/2023 at 9:56 AM, Surveyor emailed Director A and asked how to locate resident satisfaction surveys in the electronic record system. At 10:14 AM, Director A stated, "I have forwarded the email to be answered ASAP (as soon as possible)..." At 10:23 AM, Surveyor emailed Director A and	N 392		

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MILESTONE SENIOR LIVING RENEE CBRF	5510 RENEE DR EAU CLAIRE, WI 54703

(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 392	Continued From page 27	N 392		

asked if s/he or Health Care Coordinator (HCC) B had sent or completed any resident satisfaction surveys themselves, or if they had knowledge they were completed.

At 10:24 AM, Director A responded, "We use Pinnacle, they do monthly surveys. What is the time from that you would like for the reports. Back 3 months?" Director A did not answer the question emailed at 10:23 AM.

At 10:31 AM, Surveyor requested satisfaction surveys for Resident 4 and Resident 5.

At 10:32 AM, Director A responded, "We do not have separate satisfaction surveys, we have a company do random surveys every month to family members, POA's (Power of Attorney) and residents."

At 10:43 AM, Surveyor asked Director A if the system tracked which resident/POA completed the survey, if the system they use was approved by the Department and requested Resident 4 and Resident 5's satisfaction surveys.

No response was received for the questions emailed to Director A at 10:43 AM.

At 12:41 PM, Director A emailed Surveyor 3 attachments to indicate a satisfaction survey was sent in June, July and August 2023. One of 3 surveys were anonymous.

At 5:31 PM, Director A sent an email stating s/he reviewed satisfaction surveys as the director, including the regional team. Director A stated satisfaction surveys were reviewed as they were received and internal counseling was completed with the regional team and action plans were

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N 392	Continued From page 28 completed for items noted as needing follow-up and review by an internal team and regional team. Director A did not provide an answer to the question about the system used by the facility being approved by the Department or if the system tracked who or when a satisfaction survey was sent. Satisfaction surveys, or proof that satisfaction surveys were sent to Resident 4 and Resident 5 were not received as requested. On 09/05/2023 at approximately 11:45 AM, Surveyor interviewed Regional Nurse (RN) J, Regional Director (RD) K and Compliance Manager (CM) L and asked if the system they used for resident satisfaction surveys was approved by the Department for use and informed them Director A did not respond to the questions emailed on 08/31/2023. RD K stated s/he was not aware of the request and CM L stated, "We will look into it." Surveyor informed RN J, RD K and CM L that additional information could be submitted within 2 hours. No additional information was received.	N 392		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by:	N 396		

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N 396	Continued From page 29 Based on record review and interview, the provider did not ensure there were sufficient numbers of employees on a 24-hour basis to meet the needs of all residents. This requirement is being cited for the third time. See Statement of Deficiency (SOD) NYG911, dated 07/16/2018, and SOD ZWVC11, dated 06/20/2019. Findings include: On 06/07/2023, 06/19/2023, and 07/06/2023, the Department received complaints with allegations that residents' needs were not being met. This provider is licensed to care for up to 26 residents in the client groups of: advanced age and irreversible dementia/Alzheimer's disease. On 08/22/2023, Surveyor reviewed the employee schedule for the last 3 months. The schedule was not complete as it did not include each employee's full name, job assignment and time worked. On 08/22/2023, Surveyor reviewed the resident roster. There were 18 residents. Resident 4, Resident 5, Resident 6, and Resident 7 were identified as requiring 2 staff to assist with transfers. On 08/30/2023, Surveyor emailed Director A and requested s/he identify which staff were present and working in the community based residential facility (CBRF) on the following dates: 06/07/2023, 06/16/2023, 06/17/2023, 06/24/2023, 06/25/2023, 07/01/2023, 07/02/2023, 07/03/2023, and 07/18/2023.	N 396		

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N 396	Continued From page 30 At approximately 1:10 p.m. Director A called Surveyor and stated they completed the list for the schedule and staff working, but some of the employees were not current and s/he did not have access to old employee records/payroll timesheets. S/he stated she did ask corporate and was waiting to hear back to confirm or verify if they actually worked per the schedule. At approximately 3:00 p.m., Director A emailed Surveyor a document to indicate which staff were working on the requested sampled dates. The email read, in part: "I have attached the schedule with agency added from the two different scheduling systems that we use. I am not able to 100% verify some of our staff members exact hours or if they worked or not as my reports are seeming to not pull past employees ... Staff that I am not able to verify are highlighted yellow." On 08/30/2023, Director A emailed Surveyor a document that indicated which staff were working in the CBRF and which staff were working in the RCAC (the resident care apartment complex located in the same building adjacent to the CBRF). On 08/31/2023, Director A emailed Surveyor the timecards to verify if the former employees actually worked the shift that was identified on the schedule. On 08/31/2023, Surveyor reviewed the documentation and discovered the following dates and times there was not adequate staff to meet the needs of residents that required 2 staff to assist: 06/16/2023 - 10:00 p.m. - 6:00 a.m. - Caregiver O worked alone in the CBRF. Caregiver P was on	N 396		

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the schedule, highlighted in yellow. His/her timecard did not indicate s/he worked that shift.

06/17/2023 - 10:00 p.m. - 6:00 a.m. - Caregiver Q worked in the CBRF. Caregiver R was identified as a float staff between the CBRF and the RCAC during that time.

07/01/2023 - 10:00 p.m. - 6:00 a.m. - Caregiver S worked in the CBRF. Caregiver T was identified as the only staff working in the RCAC and was also identified as a float staff for the CBRF.

07/02/2023 - 10:00 p.m. - 6:00 a.m. - Caregiver U worked in the CBRF. Caregiver V was identified as the only staff working in the RCAC and was also identified as working in the CBRF.

07/03/2023 - 10:00 p.m. - 6:00 a.m. - Caregiver R worked in the CBRF. Caregiver U was identified as working in both the CBRF and the RCAC.

On 09/05/2023 from approximately 11:00 a.m. - 1:00 p.m., Surveyors conducted an exit interview with the regional team. Surveyor asked what the normal staffing pattern was for the CBRF. Administrator H told Surveyors it would depend on the census. S/he said normally it would be 3 staff on AM and PM shift, and 2 staff on the overnight shift. S/he said with the census being low, it could be 2 staff on per shift. Surveyor asked if there should always be at least 2 staff working in the CBRF. Administrator H said, "There is always 2 on." Surveyor explained concerns that out of a sample of 9 dates, 5 of those dates identified only 1 staff or 1 staff with a float staff working in the CBRF.

The provider did not ensure there was adequate staff to meet the needs of all residents on a

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N 396	Continued From page 32 24-hour basis when they did not ensure at least 2 staff were working in the CBRF at all times. Cross Reference N0399 DHS 83.36(2) Maintain Current Written Staffing Schedule.	N 396		
N 399	83.36(2) Maintain current written staffing schedule Staffing schedule. The CBRF shall maintain a current written schedule for staffing the CBRF. The schedule shall include each employee ' s full name, job assignment and time worked. This Rule is not met as evidenced by: Based on record review and interview, the facility did not maintain a current written schedule that included the staff's full name and the actual time worked, or accurately reflected who was scheduled to work. This is a repeat deficiency. See Statement of Deficiency (SOD) 732R11, dated 12/19/2019. Findings included: The facility is a 26-bed community based residential facility (CBRF) for those who may or may not be ambulatory. Client groups included those of advanced age and/or irreversible dementia/Alzheimer's Disease. The facility had an adjoining residential care apartment complex (RCAC) with 32 apartments owned by the same licensee. The schedule for both facilities was on the same sheet. The managers covered both licensed facilities. On 08/22/2023 at 8:30 AM, Surveyors requested	N 399		

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N 399	Continued From page 33 Caregiver E provide the current and final staff schedules for the past 3 months to review. Surveyor reviewed the schedule provided by Caregiver E. The schedule included staff for both the RCAC and CBRF. Surveyor asked if the schedules could be separated to show only CBRF staff and requested a complete schedule to include management staff and support services staff (housekeeping, activities, administrative assistant, cook, etc.). Surveyor reviewed the schedules. The left side margin was cut off so the employee's full name was not available. The schedules identified staff names but also included entries labeled, "hift Key", "hift Key 2", "hift Key 3", "chedulePop Support", "gency 1", "edication aid/asser Agency". No names were entered to identify who actually worked that shift, if anyone. At 11:00 AM, Surveyor interviewed Caregiver E. Caregiver E stated s/he was told by Director A to print only the care staff schedule. Surveyor explained that the request at entrance was for the full employee schedule, including management, cooks, housekeeping, maintenance, etc. Caregiver E stated s/he could print the schedules for each department. At 12:10 PM, Caregiver E provided a document titled, "Coordinator Schedule 2023." Caregiver E explained the document showed the general work week schedule for all salaried employees. The document did not identify employee's full names or specific dates/times they worked. INTERVIEW On 09/05/2023, from 11:00 AM to 1:00 PM,	N 399		

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N 399	Continued From page 34 Surveyor interviewed Administrator H, Regional Nurse (RN) J, Regional Director (RD) K, Compliance Manager (CM) L, and RN W. Surveyor discussed concern that a complete schedule was not received as requested. Surveyor asked if there was a reason why a full, complete schedule was not provided. RN J and RD K stated they were not aware it was not provided and further stated the director facilitates schedule pop (the scheduling program) and they were not able to assist him/her. They were directed to corporate who could get the schedule. At approximately 11:40 AM, CM L asked if they could still send information to Surveyor. Surveyor stated s/he would accept information sent within 2 hours after the call. As of 09/06/2023, a complete schedule was not received.	N 399		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure weekly menus were available to residents or that deviations from the planned menu were recorded. This is a repeat deficiency. See Statement	N 450		

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N 450	Continued From page 35 Deficiency (SOD) YPZH11, dated 11/27/2018. Findings include: On 08/22/2023 at 7:50 AM, Surveyor entered the facility and began observing the morning meal service. Surveyor did not find a menu posted in the facility. At 8:09 AM, Surveyor interviewed Caregiver M (hired 08/13/2023). Caregiver M stated s/he was not sure what was for breakfast. Surveyor asked if the menu was posted anywhere and Caregiver M responded, "Not that I've seen." At 8:51 AM, Surveyor interviewed Cook D. Cook D stated s/he was the culinary coordinator for the campus. Cook D stated the menus were not posted anywhere for residents. At 11:22 AM, Surveyor interviewed Cook D. Cook D stated s/he learned about 3 weeks ago that s/he was supposed to document deviations. Cook D said s/he sent menu deviations to Director A. Cook D provided Surveyor with dated menus for dates 08/13/2023 through 09/16/2023. The menus did not include deviations. The menu indicated the evening meal on 08/21/2023 was ham and potato soup, garlic bread and an apple turnover. On 08/23/2023, Surveyor reviewed a written concern signed by 3 caregivers on 08/21/2023. The written concern read, in part: "08/21/2023...When the cook came over with supper tonight (@4:45), [s/he] plated up all the food and started to leave. We asked [him/her] if there were more sandwiches... Dinner tonight was ham & broccoli soup, 1/2 tuna sandwich & a	N 450		

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N 450	Continued From page 36 fruit cup. 11 people @ the table refused to eat the soup and were refused anything else." On 09/23/2023 at 9:35 AM, Surveyor interviewed Cook D. Cook D stated s/he discussed the written concern with Cook X who was working the evening of 08/21/2023. Cook D confirmed Cook X served soup and tuna fish sandwiches for supper on 08/21/2023. The meal served on 08/21/2023 deviated from the planned menu. The deviation was not documented on the provider's menu.	N 450		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation, interview, and record review, the provider did not ensure food was	N 452		

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N 452	Continued From page 37 distributed and served under sanitary conditions to prevent food borne illness. Hot foods were not held at 140°F or above on 08/22/2023. This is a repeat deficiency. See Statement of Deficiency (SOD) 732R11, dated 12/19/2019 and SOD NYG911, dated 07/16/2018. Findings include: In June and July 2023, the Department received complaints regarding the provider's dietary services. On 08/22/2023 at approximately 8:12 AM, Surveyor observed Maintenance Director (MD) G, Caregiver I, Caregiver M, and Caregiver N serve breakfast. MD G pulled 3 covered metal containers of food from a cart that was sitting in the kitchen and placed them in a warming tray. At 8:14 AM, Surveyor took a temperature of a sausage patty that was in one of the containers and found it to be 109°F. Surveyor observed MD G dish the first plate with a sausage patty, fried egg, and pancake. The plate sat on the counter for 7 minutes until it was taken to the dining room. At approximately 8:40 AM, Surveyor interviewed Cook D (hired 07/05/2023). Cook D stated s/he was hired 6 weeks ago as the culinary coordinator. Cook D said s/he told Director A when s/he was hired that s/he had no experience working with special diets, creating menus, or preparing meals. Cook D stated, "I've been begging for help and training... I'm just trying to wing it." Cook D stated s/he was the culinary coordinator on the provider's campus and s/he had 2 cooks that filled dietary shifts when Cook D was not on site.	N 452		

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N 452	Continued From page 38 On 08/23/2023 at approximately 9:34 AM, Surveyor interviewed Cook D via phone. Surveyor requested the facility's temperature logs. Cook D stated s/he did not know she was supposed to take the temperature of food prior to serving and stated s/he was not told or shown how to properly take the temperature of food. Cook D stated s/he did not know what safe holding temperatures were and stated s/he did request to complete ServSafe training on 08/10/202, but Director A told Cook D s/he did not need the ServSafe certification to do the job. Cook D admitted s/he was not checking temperatures regularly. Cook D stated s/he found the temperature logs last week Friday and [Cook X] was not doing them at night. Temperature logs for the facility's freezers (3) and refrigerators (2) indicated the facility's procedure was to record temperatures twice daily; however, documentation and temperatures were not completed. According to the United States Department of Agriculture, "Leaving food out too long at room temperature can cause bacteria to grow to dangerous levels that can cause illness. Bacteria grow most rapidly in the range of temperatures between 40° F and 140° F, doubling in number in as little as 20 minutes. This range of temperature is often called the 'Danger Zone.'...Keep hot food hot-at or above 140° F...Keep cold food cold-at or below 40° F." (Source: United States Department of Agriculture-Food Safety and Inspection Service, Danger Zone, 06/28/2017, https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/danger-zone-40f-140f (retrieval date 09/05/2023).) Cross reference:	N 452		

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N 452	Continued From page 39 N0215 DHS 83.15(3)(b) Administrator Responsible For Staff Training	N 452		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drills were completed at least quarterly in 2022. The provider did not document the time of the fire drills that were completed in 2023. Findings include: This provider is licensed to care for up to 26 residents in the client groups of advanced age and irreversible dementia/Alzheimer's disease. On 08/22/2023, Surveyor reviewed the provider's	N 525		

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N 525	Continued From page 40 safety reports. Surveyor did not locate any fire drills that were conducted in 2022. There were 2 documented fire drills for 2023, dated 03/30/2023 and 04/27/2023. The time of day the fire drills took place was not documented. On 08/22/2023 at approximately 3:30 p.m., Surveyor interviewed Maintenance Director (MD) G and asked if there were any additional fire drills. MD G told Surveyor there were multiple new and agency staff and s/he conducted in-service training with the new staff to review emergency procedures, which included fire drills, but s/he did not always conduct a fire drill. On 08/22/2023 at 4:45 PM, requested documentation not yet received from Health Care Coordinator (HCC) B, which included any additional fire drills completed. On 08/28/2023, Surveyor reviewed additional information that was faxed from the provider. There was no documentation for fire drills completed in 2022.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure emergency or other evacuation drills were completed at least semi-annually in 2022 and the first half of 2023. Findings include:	N 526		

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N 526	Continued From page 41 This provider is licensed to care for up to 26 residents in the client groups of advanced age and irreversible dementia/Alzheimer's disease. On 08/22/2023, Surveyor reviewed the provider's safety reports. Surveyor did not locate any "other" evacuation drills conducted in 2022 or 2023. In 2023, there was documentation of staff training on their response to the door opening and an escalating phone call. On 07/27/2023, there was documentation of an in-service training on tornado drills, however this did not include an evacuation. On 08/22/2023 at 4:45 PM, requested documentation not yet received from Health Care Coordinator (HCC) B which included any other evacuation drills for 2022 and 2023. On 08/28/2023, Surveyor reviewed additional information that was faxed from the provider. There was no documentation of other evacuation drills in 2022 or 2023.	N 526		
Z 012	50.065(2)(bm) OUT OF STATE BACKGROUND CHECKS If the person who is the subject of the search under par. (am) or (b) is not a resident of this state or if at any time within the 3 years preceding the date of the search that person has not been a resident of this state, or if the department or entity determines that the person's employment, licensing, or state court records provide a reasonable basis for further investigation, the department or the entity shall make a good faith effort to obtain from any state or other United	Z 012		

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Z 012	Continued From page 42 States jurisdiction in which the person is a resident or was a resident within the 3 years preceding the date of the search information that is equivalent to the information specified in par. (am) 1. or (b) 1. The department or entity may require the person to be fingerprinted on 2 fingerprint cards, each bearing a complete set of the person's fingerprints. The department of justice may provide for the submission of the fingerprint cards to the federal bureau of investigation for the purposes of verifying the identity of the person fingerprinted and obtaining the records of his or her criminal arrests and convictions. This Rule is not met as evidenced by: Based on record review and interview, the provider did not make a good faith effort to obtain an out-of-state criminal record check for 1 of 1 employee sampled (Caregiver F). Findings include: On 08/22/2023, Surveyor requested 5 employee records for review. Caregiver F's record (hired 06/09/2023) included a background information disclosure (BID) form signed by Caregiver F on 05/24/2023. The BID indicated Caregiver F lived in Minnesota within 3 years preceding 05/24/2023. Caregiver F's record did not include a criminal record report for Wisconsin or any other state. At 4:29 PM, Surveyor interviewed Health Care Coordinator (HCC) B. HCC B stated Director A was responsible for hiring new employees. Director A was on paid time off during so HCC B	Z 012		

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Z 012	Continued From page 43 made a list of the items Surveyor needed to complete the survey. Surveyor discussed needing Caregiver F's complete caregiver background check, including an out-of-state criminal record report. On 08/23/2023 at 2:55 PM, Surveyor interviewed Director A. Director A stated s/he had information to send Surveyor for review. As of 09/05/2023, Surveyor did not receive additional caregiver background check documentation for Caregiver F. On 09/05/2023 from 11:00 AM to 1:00 PM, Surveyor interviewed Administrator H, Regional Nurse (RN) J, Regional Director (RD) K, Compliance Manager (CM) L, and RN W. Surveyor discussed concern that Caregiver F did not have a completed CBC on file. At approximately 11:40 AM, CM L asked if they could still send information to Surveyor. Surveyor stated s/he would accept information sent within 2 hours after the call. As of 09/06/2023, Surveyor did not receive additional caregiver background check documentation for Caregiver F. Cross reference: N0219 DHS 83.17(1) Licensee Conduct Caregiver Background Check	Z 012		
Y3098	50.07 PROHIBITED ACTS 50.07 Prohibited acts. (1) No person may: (a) Intentionally fail to correct or	Y3098		

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Y3098	Continued From page 44 interfere with the correction of a class A or class B violation within the time specified on the notice of violation or approved plan of correction under s. 50.04 as the maximum period given for correction, unless an extension is granted and the corrections are made before expiration of extension. (b) Intentionally prevent, interfere with, or attempt to impede in any way the work of any duly authorized representative of the department in the investigation and enforcement of any provision of this subchapter. (c) Intentionally prevent or attempt to prevent any such representative from examining any relevant books or records in the conduct of official duties under this subchapter. (d) Intentionally prevent or interfere with any such representative in the preserving of evidence of any violation of any of the provisions of this subchapter or the rules promulgated under this subchapter. (e) Intentionally retaliate or discriminate against any resident or employe for contacting or providing information to any state official, or for initiating, participating in, or testifying in an action for any remedy authorized under this subchapter. (f) Intentionally destroy, change or	Y3098		

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Y3098	Continued From page 45 otherwise modify an inspector?s original report. (2) Violators of this section may be imprisoned up to 6 months or fined not more than $1,000 or both for each violation. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure full cooperation with the Department's process for conducting survey and investigation work. The provider's process included requiring records requested by the Surveyor to be reviewed and approved by their Director and corporate regional management team prior to state inspection. This process impeded and interfered with the survey and investigation, including the timeline and integrity of the unannounced review. Findings Include: The Division of Quality Assurance (DQA) Memo (13-011), dated 04/18/2013 titled, "Electronic Records" states that per statutory requirements: "The Bureau of Assisted Living (BAL) surveyor must be able to conduct the inspection process in a consistent manner in all facilities and must be allowed access to records regardless of whether the facility uses paper or electronic records. The surveyor will cooperate with the facility to establish a process in which the surveyor will have unrestricted and timely access (within two hours) to the records..." On 08/22/2023 at approximately 7:50 AM,	Y3098		

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Surveyors entered the facility and asked to speak to the administrator or person in charge. Director A was identified as the person in charge of the community but was not present in the facility as staff reported s/he was "on vacation" and not able to be present at the time of survey.

MENUS

At approximately 8:40 AM, Surveyor interviewed Cook D. Cook D stated s/he was hired 6 weeks ago as the culinary coordinator. Surveyor asked to see the menus, including deviations from menus and alternatives. Cook D showed Surveyor the weekly rotation of menus s/he had created since s/he was hired.

At approximately 8:50 AM, Cook D looked at his/her smart watch and stated Director A keeps calling him/her. Cook D stated, "[S/he's] probably calling to tell me not to talk to you."

A couple minutes later, a caregiver entered the kitchen with a cell phone. The caregiver stated Director A was on the line and needed to talk to Cook D. Cook D took the phone call. The volume was up high enough for Surveyor to hear Director A. Director A stated "State" needed Cook D's menus. Cook D stated s/he was aware and that s/he was showing a surveyor the menus right now. Director A stated, "Don't do that. That's why I tried calling you." Director A explained to Cook D that everything needed to go through Director A before Surveyor could have it.

Cook D ended the phone call. Surveyor asked if s/he could get a copy of the menus they were discussing. Cook D took the menu that Surveyor was looking at and stated, "[Director A] said I can't give you guys anything you ask for ...I'm so

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over this."

Surveyor reviewed text messages with time stamps between Cook D and Director A after Cook D was told not to provide information as requested:

Director A: "Please send me a picture of what you provided them today [sic]" 8:57 AM
Cook D: [Photo of the menu for one week Sunday-Saturday with Breakfast, Lunch and Supper meals, not dated] 8:58 AM
Director A: "[Cook D] I need three months please. Not three weeks" 9:17 AM
Director A: "Okay ????" 9:18 AM
Cook D: "Of menus? I don't have 3 months I was unaware I needed 3 months of menus at the ready. This is why I need trained [sic]" 9:19 AM
Director A: "[Cook D], I understand that you need to be trained right now. I need you to print all of your menus and start reading [sic] dates on them from three months ago. Please do it as soon as possible and scan it in." 9:19 AM
Director A: "Writing ********" 9:20 AM
Cook D: "I don't have 3 months of menus 9:23 AM
Director A: "Rotate the knees [sic] you have please !" 9:23 AM
Cook D: "I've only worked for 5 weeks thats [sic] all I have" 9:24 AM
Director A: "[Cook D] I need you to put dates on the menus going back 3 months . [sic] Doesn't matter if you were there or not others were." 9:24 AM
Cook D: "[Director A] I am not comfortable lying to a government affiliate. That seems like that's what you're asking me to do." 9:25 AM
Director A: "[Cook D] they ate !" 9:27 AM
Cook D: "I understand they ate but it isn't what is on these menus. Where are the old menus? I'll

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be happy to send those to you." 9:34 AM

Director A asked Cook D to alter menus prior to his/her employment, directed Cook D not to talk to Surveyors or provide documentation without getting his/her approval. Director A provided Surveyor with altered menus dated from 06/21/2023-08/26/2023. The menus were inaccurately altered by Director A as the menu and meals served by Cook D on the date of survey (08/22/2023) did not match the dated menu provided by Director A.

STAFF SCHEDULES

On 08/22/2023 at 8:30 AM, Surveyors requested Caregiver E provide the current and final staff schedules for the past 3 months to review.

On 08/22/2023 at approximately 10:20 AM, Surveyor spoke to Director A via phone and informed him/her that a complete schedule for all employees, including management and support service staff (Housekeeping, Nurse, Administrative Assistant, Dietary, Activities, Maintenance, etc.) was requested at approximately 8:30 AM.

At 11:00 AM, Surveyor interviewed lead caregiver, Caregiver E. Caregiver E stated s/he was told by Director A to print only the care staff schedule. Surveyor explained that the request at entrance was for the full employee schedule, including management, cooks, housekeeping, maintenance, etc. Caregiver E stated s/he could print the schedules for each department.

On 08/22/2023, at 11:20 AM, Surveyors had not received a complete schedule. Caregiver E provided a document titled, "Coordinator

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Schedule 2023." Caregiver E explained the document showed the general work week schedule for all salaried employees. The document did not identify employee's full names or dates/times they worked. Caregiver E stated, "This is what I was told to give you."

Caregiver E previously stated s/he could print the schedules with the positions but did not get approval from Director A to provide them. A complete accurate schedule was not received.

ACCESS TO RECORDS

On 08/22/2023 at approximately 10:15 AM, Surveyors requested from Director A, unrestricted access to resident records to choose a sample to verify compliance. The facility uses an electronic charting system. At approximately 11:15 AM, HCC B informed Surveyors s/he was waiting for log-in information. At 1:45 PM, Surveyors did not have access to resident records. At that time, HCC B informed Surveyors that access would be granted once a resident sample was identified. Surveyors chose a sample and requested access to records for Resident 1, Resident 2, Resident 3, Resident 4, Resident 5 and Resident 8.

On 08/22/2023 at 4:02 PM, Surveyors verified with HCC B that resident records were still not available for review. HCC B stated s/he sent an email to Director A and Regional Nurse (RN) J at 2:07 PM with the sample request.

On 08/23/2023 at approximately 2:55 PM, Director A contacted Surveyor via phone and stated s/he would be sending over outstanding documentation for review. RN J and HCC B were present at the time of the call.

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Y3098	Continued From page 50 On 08/23/2023 at approximately 3:00 PM, Surveyor attempted to log in to the facility's charting system and did not have access to records. Surveyor asked Director A if there was an update on why access to records was not-granted. Director A stated s/he had received an email stating corporate provided access so s/he thought Surveyors had access. At 3:10 PM, HCC B attempted to log in to the electronic record system with the username and password provided. HCC B confirmed records were not available for review. Surveyor was granted access at 3:14 PM. Surveyor asked Director A, HCC B and RN J if complete records were available on the electronic system. HCC B confirmed that all records should be accessible. HCC B stated, "The only thing that wouldn't be in there is misconduct incident reports, internal investigation reports which are internal forms." Unrestricted access to resident records was not provided as requested. Surveyors were delayed in reviewing resident records when it took the facility over 24 hours to provide access. INTERVIEW On 09/05/2023 at approximately 11:10 AM, Surveyor discussed the above concerns of delayed access to the items listed above with Regional Nurse (RN) J, Regional Director (RD) K and Compliance Manager (CM) L. Surveyor asked if Director A could join the call but was informed Director A was on vacation. Administrator H and RN W also joined the call. Surveyor asked if it was a company policy for the regional team to review everything prior to handing information over for review. RN J stated, "No, they assist director and facility." RN J further	Y3098		

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Y3098	Continued From page 51 stated that they may need to go to corporate if there was a report needed that could not be generated.. Surveyor then asked if there was a reason why a full, complete schedule was not provided. RN J and RD K stated they were not aware it was not provided and further stated the director facilitates schedule pop (the scheduling program) and they were not able to assist him/her and were directed to corporate who could get the schedule. Surveyor discussed the concern with RN J, RD K and CM L that menus reviewed in the kitchen did not match up with the menus provided by Director A. RN J stated s/he was not sure why the menus were different and informed Surveyor there was no reason menus should have been restricted from access. Surveyor informed RN J, RD K, CM L, Administrator H and RN W that additional information could be submitted within 2 hours. No additional information was received regarding the items discussed above. SUMMARY Wis. Stat § 50.07 reads, in part: "(1) No person may: (b) Intentionally prevent, interfere with, or attempt to impede in any way the work of any duly authorized representative of the department in the investigation and enforcement of any provision of this subchapter. (c) Intentionally prevent or attempt to prevent any such representative from examining any relevant books or records in the conduct of official duties under this subchapter." Director A was identified as the person responsible for the day-to-day operations of the	Y3098		

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Y3098	Continued From page 52 licensed CBRF. Director A impeded the survey process by preventing access to complete and accurate records.	Y3098		