STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017057	A. BUILDING: _____ B. WING _____	R-C 03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 03/19/2024, Surveyors conducted a verification visit and three complaint investigations at Milestone Senior Living Renee. Data collection continued through 03/26/2024. One of three complaints was substantiated. Five deficiencies were identified and were repeat deficiencies. See Statement of Deficiency (SOD) TLWS11, dated 09/05/2023, SOD 732R11, dated 12/19/2019, SODZWVC11, dated 06/20/2019, SOD 9HCZ11, dated 10/25/2018, SOD YPVH11, dated 11/27/2018, and SOD NYG911, dated 07/16/2018. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 15	{N 000}		
{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 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:	{N 230}		

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

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{N 230}	Continued From page 1 Based on record review and interview, the provider did not provide Cook O 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 performing any job duties. This is a repeat deficiency. See Statement of Deficiency (SOD) TLWS11, dated 09/05/2023, and SOD 732R11, dated 12/19/2019. Findings include: On 03/19/2024, Surveyor requested to review employee records for orientation training. The employee roster identified Cook O had a hire date of 02/21/2024. On 03/19/2024 at 9:45 AM, Surveyor interviewed Cook O. Cook O stated s/he began employment approximately 3 weeks ago and was still training. Cook O stated s/he was working 60(+) hours to help provide relief in the kitchen as there was only one other employee staffed in the kitchen to cook. Cook O stated s/he had not received or completed any training from the provider. On 03/19/2024 at 10:00 AM, Director A confirmed Cook O had not completed orientation training prior to performing job duties. On 03/19/2024 at approximately 2:20 PM, Surveyor interviewed Director A about the	{N 230}		

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{N 230}	Continued From page 2 orientation process for new employees. Director A stated there was not a specific orientation process in place and informed Surveyor they recently implemented a new orientation checklist to use going forward. On 03/19/2024 at 2:26 PM, Regional Registered Nurse (RN) M informed Surveyor their plan was to have each employee go back and complete the new orientation checklist.	{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 complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties.	{N 239}		

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{N 239}	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 5 employees obtained department-approved training in standard precautions as required. This requirement is being cited for the fourth time. See Statement of Deficiency (SOD) 9HCZ11, dated 10/25/2018, SOD 732R11, dated 12/19/2019, and SOD TLWS11, dated 09/05/2023. Findings include: On 03/19/2024, Surveyor conducted a review of 5 employees to verify compliance with department-approved training requirements. Surveyor requested training records from Director A. The record for Cook O, hired 02/21/2024, did not contain evidence of training or evidence of meeting an exemption for standard precautions. On 03/19/2024 at approximately 9:45 AM, Surveyor interviewed Cook O and asked what his/her job responsibilities were. Cook O stated s/he began employment approximately 3 weeks ago and was still training. Cook O stated s/he was working 60(+) hours to help provide relief in the kitchen as there was only one other employee staffed in the kitchen to cook. Cook O stated s/he had not received or completed training in standard precautions. Cook O stated s/he occasionally brings food to the residents and serves plates to residents. Cook O stated s/he assists residents cut up their	{N 239}		

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{N 239}	Continued From page 4 food if necessary and has exposure to utensils and plates used by the residents to clean dishes, as well as exposure to blood, body fluids or other moist body substances. On 03/19/2024 at approximately 10:00 AM, Surveyor interviewed Director A and asked if Cook O had received training in standard precautions. Director A confirmed Cook O had not completed standard precautions training prior to assuming job duties. On 03/19/2024, Surveyor verified Cook O was not on the Community-Based Care and Treatment training registry for standard precautions.	{N 239}		
{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 implement the individual service plan (ISP) for 1 of 2 residents that required a special diet. Resident 1 had an order for a mechanical diet. Staff did not provide Resident 1 with a mechanical diet at lunch. This requirement is being cited for the third time. See Statement of Deficiency (SOD) YPVH11, dated 11/27/2018, and SOD TLWS11, dated 09/05/2023. Findings include:	{N 388}		

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{N 388}	Continued From page 5 On 03/19/2024 at approximately 9:30 a.m., Surveyor interviewed Resident Assistant (RA) C. Surveyor asked which residents required a special diet. RA C told Surveyor Resident 1 and Resident 2 were on a mechanical soft diet. On 03/19/2024 at approximately 12:10 p.m., Surveyor observed lunch. Cook A served the food from the steam table and RA D served the residents. The lunch consisted of a slice of ham, pasta, and squash. At 12:20 p.m., Surveyor observed lunch and interviewed Cook E. Surveyor observed Resident 1 was provided a regular lunch of ham, pasta, and squash. Surveyor asked Cook E if Resident 1's lunch was mechanical soft. Cook E observed Resident 1's lunch and told Surveyor it was not mechanical soft. Cook E told RA D that Resident 1 did not receive a mechanical soft lunch. Cook E told Surveyor that previously it was the cook's responsibility to ensure each resident received the correct diet. Cook E said that recently the responsibility was passed to the resident assistants. Cook E explained that Resident 1 was on a mechanical soft diet due to his/her family's request. S/he said Resident 1 did not have any choking episodes that s/he was aware of. On 03/19/2024, Surveyor reviewed Resident 1's record. Resident 1's ISP, effective date 01/09/2024, indicated Resident 1 had an order for a mechanical soft diet.	{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	{N 389}		

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{N 389}	Continued From page 6 or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the individual service plan (ISP) for 2 of 2 residents that required a special diet was updated to reflect their current needs. This is a repeat deficiency. See Statement of Deficiency (SOD) TLWS11, dated 09/05/2023. Findings include: On 03/19/2024 at approximately 9:30 a.m., Surveyor interviewed Resident Assistant (RA) C. Surveyor asked which residents required a special diet. RA C told Surveyor Resident 1 and Resident 2 were on a mechanical soft diet. At 12:20 p.m., Surveyor observed lunch and interviewed Cook E. Surveyor observed Resident 1 was provided a regular lunch of ham, pasta, and squash. Surveyor asked Cook E if Resident 1's lunch was mechanical soft. Cook E observed Resident 1's lunch and told Surveyor it was not mechanical soft. Cook E told RA D that Resident 1 did not receive a mechanical soft lunch. Cook E told Surveyor that previously it was the cook's	{N 389}		

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{N 389}	Continued From page 7	{N 389}		

responsibility to ensure each resident received the correct diet. Cook E said that recently the responsibility was passed onto the resident assistants. Cook E explained to Surveyor that Resident 1 was on a mechanical soft diet due to his/her family's request. S/he said Resident 1 did not have any choking episodes that s/he was aware of. Cook E told Surveyor Resident 2 was on a pureed diet after Resident 2 was discharged from the hospital. S/he explained that hospice had recently changed Resident 2 from a pureed diet to a mechanical soft diet.

On 03/19/2024, Surveyor reviewed Resident 1 and Resident 2's record.

Resident 1's ISP, with an effective date of 01/09/2024, contained his/her orders. Resident 1 had an order for a mechanical soft diet. Resident 1's ISP for meal consumption indicated a goal of: "To provide assistance for meal consumption service." The action was, "Staff will offer snacks between meals and offer more second portion with meals if resident desires." A second meal consumption entry indicated a goal of nutrition. The action was: "Monitor nutrition. Staff will monitor and document at every meal percentage of intake as 0%, 25%, 50%, 75%, or 100%."

Resident 1's ISP included his/her order for the mechanical soft diet, but the ISP did not indicate the mechanical soft diet as a service under the assessed need for meal consumption. The ISP did not indicate who was responsible for delivering a mechanical soft diet to Resident 1.

Resident 2 had a dietary order, dated 03/08/2024, for a mechanical soft diet.

Resident 2's ISP, with an effective date of

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{N 389}	Continued From page 8 02/19/2024, indicated under meal consumption, a goal of: "Choking Risk: Resident will maintain and/or maximize nutritional status without any negative outcomes related to choking ...." The action identified, read, in part: "Encourage resident to eat in an upright position, to eat slowly. Meals will be pureed ..." Resident 2's ISP was not updated to reflect the change in diet from pureed to mechanical soft. On 03/19/2024 at approximately 3:30 p.m., Surveyor interviewed Registered Nurse (RN) B. RN B told Surveyor that s/he did the ISP updates along with the previous director of nursing who recently left. Surveyor asked how RN B ensured a resident's ISP was updated with changes. RN B explained that if a resident had a change in condition, s/he would do an assessment along with an updated ISP. Surveyor explained concerns with Resident 1 and Resident 2's ISPs related to their diets. RN B said s/he would update the ISPs. RN B said they have a new electronic records system that they were all still learning to use. Cross Reference: N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan	{N 389}		
{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: Based on record review and interview, the provider did not ensure there were sufficient	{N 396}		

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{N 396}	Continued From page 9 numbers of employees on a 24-hour basis to meet the needs of all residents. This requirement is being cited for the fourth time. See Statement of Deficiency (SOD) NYG911, dated 07/16/2018; SOD ZWVC11, dated 06/20/2019; and SOD TLWS11, dated 09/05/2023. Findings include: On 12/26/2023 and 01/29/2024, the Department received complaints with allegations there was not adequate staff to meet the residents' needs. This provider is licensed to care for up to 26 residents in the client groups of: advanced age and irreversible dementia/Alzheimer's disease. The community based residential facility (CBRF) is in the same building as the residential care apartment complex (RCAC), with a shared common entryway. On 03/19/2024, Surveyor reviewed the resident roster. The roster identified 2 residents that required 2 staff to assist with transfers and/or ambulation, Resident 3 and Resident 4. The roster identified 2 residents that required 2 staff to assist with transfers and/or ambulation at times, Resident 5 and Resident 6. On 03/19/2024 at approximately 10:15 a.m., Surveyor interviewed Housekeeper F. The employee roster indicated Housekeeper F had been an employee since 2010. Surveyor asked if s/he observed any concerns related to resident care. Housekeeper F said they could use more staff. S/he said the resident assistants took shortcuts and did not always comb the residents' hair or brush their teeth during morning cares.	{N 396}		

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{N 396}	Continued From page 10 S/he said they do not always immediately remove soiled items from the residents' rooms, which caused odors. On 03/19/2024 at approximately 10:25 a.m., Surveyor interviewed Resident Assistant (RA) D. Surveyor asked if there were always 2 staff in the CBRF. S/he replied, "Yes, at least try to have 2 staff, but if there is a no show or call in, then we have to improvise." On 03/19/2024 at approximately 11:30 a.m., Surveyor interviewed RA G. RA G said staffing was most difficult on the weekends. S/he said sometimes agency staff did not show or would just leave after their shift when there was a call-in, which left them with not having enough staff. S/he said one weekend in February, s/he was the only person working. On 03/19/2024, Surveyor reviewed the employee schedule and timesheets for 02/17/2024 and 02/18/2024. On 02/17/2024, the schedule indicated RA H and RA I worked from 10:00 p.m. - 6:00 a.m. The timesheet for RA H indicated s/he left at 5:03 a.m., which would have left RA I alone in the CBRF for an hour until the morning shift arrived. On 02/18/2024, the schedule indicated RA G and RA J worked from 6:00 a.m. - 2:00 p.m. RA G and RA J's timesheets confirmed they started at 6:00 a.m. The schedule indicated RA K worked the RCAC from 6:00 a.m. - 2:00 p.m. His/Her timesheet indicated s/he did not arrive until 7:49 a.m. There were no staff working in the RCAC from 6:00 a.m. - 7:49 a.m., which would have made staff from the CBRF responsible for the RCAC.	{N 396}		

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{N 396}	Continued From page 11 On 02/18/2024, the schedule indicated RA H and RA L worked from 10:00 p.m. - 6:00 a.m. RA H's timesheet indicated s/he left at 4:44 a.m. This would have left RA L alone in the CBRF from 4:44 a.m. - 6:00 a.m. On 03/19/2024 at approximately 3:45 p.m., Surveyor interviewed Director A, Registered Nurse (RN) B, Regional RN M, and Compliance Officer N. Surveyor asked about a weekend in February when RA G arrived and there was not enough staff. Director A said s/he remembered when RA G called, and s/he came in and RN B also arrived to work. S/he said RA G was not the only staff working. Surveyor reviewed timesheets and the schedule with Director A for the weekend of 02/17/2024 and 02/18/2024. Surveyor requested documentation of timesheets to indicate who worked to cover when RA I left at 5:03 a.m. and 4:44 a.m. Surveyor also requested documentation to indicate who worked the morning of 02/18/2024, when there was no staff working in the RCAC from 6:00 a.m. - 7:49 a.m. Surveyor did not receive any other documentation to show there was more than 1 staff present in the CBRF after Caregiver I left early and when there was no staff in the RCAC. On 03/26/2024 at approximately 12:30 PM, Surveyor followed up with Director A as no information was received. Director A stated that RN B (confirmed through text message history) reported to work on 02/18/2024 and arrived "a little before 6:00 a.m." Director K informed Surveyor there was still a timeframe (approximately 45 minutes) where there was not adequate staff. Director A informed Surveyor RA G had been re-trained to call someone	{N 396}		

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{N 396}	Continued From page 12 immediately if s/he is left alone in the future. Director A further stated all staff have also re-signed the new policy and procedure to stay at a minimum of 4 hours, or until their replacement arrives if there is a no-call/no-show. The provider did not ensure there was adequate staff at all times in the CBRF.	{N 396}		