STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017638	A. BUILDING: _____ B. WING _____	C 01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL TOWER RESIDENCE	**1500 ODAY ST MERRILL, WI 54452**

(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 01/11/2024, Surveyor conducted a standard licensure survey at Bell Tower Residence. Data collection continued through 01/18/2024. One deficiency was identified. Census: 77	N 000		
Y3100	50.09(1)(f) RESIDENT'S RIGHTS IN CERTAIN FACILITIES (2) The department, in establishing standards for nursing homes and community based residential facilities may establish, by rule, rights in addition to those specified in sub. (1) for residents in such facilities. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the privacy of 2 of 8 Residents during a medication pass. Resident 2's blood sugar was checked at the dining room table in the presence of other residents and Caregiver B talked about Resident 1's medication in front of other residents. Findings include:	Y3100		

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

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Y3100	Continued From page 1 The facility is licensed to serve up to 90 residents in the client groups advanced aged, irreversible dementia/Alzheimer's and physically disabled. On 01/11/2024 at 12:40 PM, Surveyor observed the following: Caregiver B told Resident 1 it was time to take his/her medications and mentioned the medications by name (acetaminophen & risperidone) out loud in front of other residents during the noon meal. On 01/11/2024 at 12:50 PM, Surveyor observed the following during a medication pass: Caregiver B checked Resident 2's blood sugar in the dining room during the noon meal. Caregiver B told Resident 2 that Caregiver B needed to check his/her blood sugar. Caregiver B pulled Resident 2 a few inches away from the dining room table and checked Resident 2's blood sugar via finger. Resident 2 was sitting with three other residents. On 01/11/2024 at 1:05 PM, Surveyor interviewed Caregiver B. Surveyor asked Caregiver B if it was common practice to check Resident 2's blood sugar during a meal and if it was common to discuss resident medications in front of other residents. Caregiver B stated, "I usually don't do that." Caregiver B indicated that s/he usually checks Resident 2's blood sugars one hour before meals and in private away from other residents. Caregiver B reported that Resident 2 was not available before the noon meal. Caregiver B told Surveyor that s/he should not discuss resident medications in front of others. On 01/16/2024 at 10:31 AM, Surveyor emailed Administrator A and asked Administrator A about the expectation for passing medications and blood sugar checks during mealtimes in the	Y3100		

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Y3100	Continued From page 2 dining room. On 01/16/2024 at 12:12 PM, Administrator A responded, "The medication passers are instructed they may give oral medications in the dining room as long as those medications do not require vital sign parameters. Medications such as eye drops, nasal sprays, insulin, and blood sugar checks are expected to be done in the resident room or a private area." On 01/18/2024 at 12:40 PM, Surveyor interviewed Administrator A. Surveyor talked with Administrator A about Surveyor's medication pass observation on 01/11/2024 . Administrator A indicated that s/he agreed staff should not be checking resident blood sugars in the dining room and staff should not be talking about resident medications in the presence of other people. Administrator A stated that s/he would address the privacy concern and conduct some staff education.	Y3100		