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{N 000}	Initial Comments On 06/20/2024, with information gathered through 07/01/2024, Surveyor conducted a standard licensure survey, a verification visit, a self-report review, and 2 complaint investigations. Eighteen deficiencies were identified. Four of 18 deficiencies were repeat violations. See Statement of Deficiency (SOD) UK3M11 and SOD BYVS11. Two of 2 complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 7	{N 000}		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the Department within 3 working days when 1 of 1 resident (Resident 4) sustained a fall and received stitches due to his/her injuries. Findings include: On 03/05/2024, the Department received a concern alleging a resident had fallen and	N 165		

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

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N 165	Continued From page 1 received stitches due to his/her injuries. On 06/20/2024, Surveyor reviewed Resident 4's record: Resident 4 was admitted to the facility, 10/26/2023, with diagnosis including seizures. Resident 4's record contained the following "Provider Incident Report Form" which documented: 02/19/2024: Fall in hallway on way to bathroom. Cut/gash above right eyebrow. Had auras before ambulance arrived. Never lost consciousness. (Resident 4) had been sleeping and gotten up to use the bathroom when incident occurred. On 06/20/2024, at approximately 2:00 PM, Surveyor interviewed Director E. Surveyor asked if the incident on 02/19/2024, regarding Resident 4, had been reported to the Department. Director E stated s/he was not employed by the provider during that incident. On 06/26/2024, Surveyor reviewed the Department file and noted that no written reports had been submitted to the Department regarding Resident 4's 02/19/2024 fall, which resulted in medical treatment.	N 165		
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	N 239		

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N 239	Continued From page 2 training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 employee obtained all department approved training as required. Caregiver F, who had responsibilities for medication administration, did not have training in medication administration and management prior to assuming these duties. Findings include: On 03/05/2024 and 05/21/2024, the Department received concerns that staff were not properly trained in medication administration. On 06/20/2024, Surveyor reviewed Caregiver F's record.	N 239		

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N 239	Continued From page 3 The record for Caregiver F, hired prior to 02/2024, did not contain evidence of training or evidence of meeting an exemption for medication administration prior to administering Resident 2's and Resident 3's medications. On 06/20/2024, Surveyor verified Caregiver F was not on the Community-Based Care and Treatment training registry until 04/24/2024 for medication administration. On 06/20/2024, Surveyor reviewed Resident 2's and Resident 3's record. Resident 2's and Resident 3's March 2024 Medication Administration Record documented that Caregiver F had administered the 8:00 PM medications during 17 scheduled shifts. On 06/20/2024, at approximately 2:00 PM, Surveyor interviewed Licensee A, via telephone, and Director E. Licensee A stated s/he thought staff had 90 days to become certified in medication administration.	N 239		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid.	N 277		

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N 277	Continued From page 4	N 277		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 1 staff (Caregiver G) record reviewed received all required continuing education in 2022 and 2023.

Findings include:

On 06/20/2024, Surveyor requested and reviewed Caregiver G's employee file.

Caregiver G was hired prior to 08/2021.

Caregiver G's training record documented 11 hours of continuing education for 2022 but did not have evidence of receiving required training in Resident Rights, Preventing & Reporting Abuse, Standard Precautions, and Emergency Procedures including First Aid.

Caregiver G's training record documented 2 hours of continuing education for 2023 but did not have evidence of receiving required training in Preventing & Reporting Abuse, Fire Safety and Emergency Procedures including First Aid.

On 06/21/2024, at approximately 3:30 PM, Surveyor interviewed Administrator A and discussed the number of hours that are required in continuing education and what topics need to be covered. Administrator A was aware of the topics but stated that training got behind with the Covid pandemic.

On 06/20/2024, at approximately 2:30 PM, Surveyor interviewed Director E. Director E

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N 277	Continued From page 5 stated s/he had only been employed by the provider for approximately 2 months and confirmed s/he provided Surveyor with all continuing education documentation that s/he was able to locate. As of 07/01/2024 at 4:00 PM, Surveyor did not receive any additional documentation.	N 277		
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 have documentation for 1 of 1 resident record reviewed (Resident 3) for health screening for clinically apparent communicable disease, including tuberculosis (TB) within 90 days before or 7 days after admission from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse.	N 302		

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N 302	Continued From page 6 Findings include: On 06/20/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on 03/01/2024. Resident 3's record did not contain a communicable disease screen, including TB. On 06/20/2024, at approximately 1:30 PM, Surveyor interviewed Director E. Director E stated s/he had been with the provider for approximately 2 months and could not provide an explanation why Resident 3's record did not contain a communicable disease screen, including TB. Director E stated s/he would reach out to Resident 3's primary physician. As of 07/01/2024 at 4:00 PM, Surveyor did not receive any additional documentation.	N 302		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of	N 310		

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N 310	Continued From page 7 a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 resident's (Resident 2 and Resident 5) admission agreement included the description of services covered and not covered in the agreement and the corresponding rate; the method for notifying residents of a change in charges for services; what method of payment would be accepted; and the terms for holding and charging for a resident's room during a temporary absence. Findings include: On 06/20/2024, Surveyor reviewed Resident 2's record.	N 310		

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N 310	Continued From page 8 Resident 2 admitted to the facility on 11/16/2022. Resident 2's admission agreement was signed by him/her on 03/31/2023. The admission agreement did not include the description of services covered and not covered in the agreement and the corresponding rate; the method for notifying residents of a change in charges for services; what method of payment would be accepted; the terms for holding and charging for a resident's room during a temporary absence. Resident 5 admitted to the facility on 07/20/2021. Resident 5's admission agreement was signed by him/her on 07/20/2021. The admission agreement did not include the description of services covered and not covered in the agreement and the corresponding rate; the method for notifying residents of a change in charges for services; what method of payment would be accepted; the terms for holding and charging for a resident's room during a temporary absence. On 06/20/2024, at approximately 1:30 PM, Surveyor interviewed Director E and Licensee A, via telephone. Director E stated s/he had been with the provider for approximately 2 months and could not provide an explanation why Resident 2's admission agreement was not properly documented. Licensee A stated s/he had updated the admission agreement since Resident 2's admittance.	N 310		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication	{N 352}		

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{N 352}	Continued From page 9 In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not administer medications for 3 of 3 residents in the intervals prescribed by a practitioner. This is a repeat deficiency. See Statement of Deficiency (SOD) UK3M11, dated 09/11/2023. Resident 2's Bupropion, Famotidine, Finasteride, Fluoxetine, Isosorbide, Vitamin D, and Metoprolol Tartrate were not administered as prescribed. Resident 3's Trulicity and acetaminophen was not administered as prescribed due to unavailability. Resident 5's Lantus Solostar (insulin), Jardiance, and Trulicity were not administered as prescribed due to unavailability. Findings Include: On 03/05/2024, the Department received a complaint alleging residents were not receiving scheduled medications. On 06/20/2024, Surveyor reviewed Resident 2's, Resident 3's and Resident 5's record. Example 1: Resident 2 On 06/20/2024, at approximately 4:00 PM, Surveyor reviewed the med cart with Co-Owner K. Surveyor and Co-Owner K noted that the	{N 352}		

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{N 352}	Continued From page 10	{N 352}		

following medications for Resident 2 had not been administered on what appeared to be 06/18/2024 8:00 AM, due to the medication still being in the blister cards: Bupropion, Famotidine, Finasteride, Fluoxetine, Isosorbide, Vitamin D, and Metoprolol Tartrate. Surveyor and Co-Owner K determined that staff did not follow a consistent pattern on what number on the blister card medications should be dispensed from during med administration. Co-Owner K stated staff are to punch on the day of the month for scheduled medications. Surveyor and Co-Owner K reviewed the back of the blister cards where staff were to initial and date when they dispensed the medication to determine the date when Resident 2 did not receive his/her medication. Surveyor and Co-Owner K also looked through Resident 2's June 2024 Medication Administration Record which did not document a rationale as to why dose(s) of medications had not been administered.

Example 2: Resident 3

Resident 3's April 2024 MAR documented:
Trulicity - Inject 3MG (milligram) subcutaneously once weekly.
The MAR documented that the medication was not available 04/20.
Acetaminophen - Take 1 tablet by mouth 3 times daily.
The MAR documented that the medication was not available 04/15 to 04/30.

Resident 3's May 2024 MAR documented:
Gabapentin - Take 1 capsule by mouth once daily at bedtime (Please call for refill).
The MAR documented that the medication was not available 05/17.
Acetaminophen - Take 1 tablet by mouth 3 times

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{N 352}	Continued From page 11 daily. The MAR documented that the medication was not available 05/01 and 05/02. Example 3: Resident 5 Resident 5's March 2024 MAR documented: Lantus Solostar - Inject 16 units subcutaneously in the morning and 36 units at bedtime. The MAR documented that the medication was not available 03/16 and 03/17. Resident 5's April 2024 MAR documented: Jardiance - Take 1 tablet by mouth once daily in the morning (Please call for refills) The MAR documented that the medication was not available 04/11. Trulicity - Inject 4.5MG subcutaneously once weekly. The MAR documented that the medication was not available 04/09. Lantus Solostar - Inject 16 units subcutaneously in the morning and 36 units at bedtime The MAR documented on 04/04 that the medication was out until 04/07. On 06/20/2024, at approximately 1:30 PM, Surveyor interviewed Director E. Director E stated s/he had been with the provider for approximately 2 months and had determined that med passers were not allowed to call the pharmacy when a medication needed to be ordered; the previous House Manager C was to be contacted and s/he would call the pharmacy. Director E stated all med passers have been retrained to contact the pharmacy when the medication is ready to be reordered and document when it was reordered.	{N 352}		

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N 355	Continued From page 12	N 355		
N 355	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making. This Rule is not met as evidenced by: Based on interview and record review, the facility did not support or promote the right of self-determination for 2 of 2 residents. Caregiver G did not allow Resident 2 and Resident 6 to make dietary decisions. Findings include: On 06/20/2024, at approximately 12:00 PM, Surveyor interviewed Resident 6. Resident 6 stated, "I like it here. I'm happy here. Previously, not so much. People weren't nice." On 06/20/2024, at approximately 12:10 PM, Surveyor interviewed Director E. Director E stated there was a staff member that had not respected Resident 6's rights. Surveyor asked if an investigation had been completed regarding the director's concerns. Director E provided Surveyor with the following write up: "04/10/2024 Allegations were made during [Resident 6's] six-month review on caregiver misconduct from [Caregiver G], a 7a-3p staff. [S/he] works four days a week. [Resident 6] stated that [Caregiver G] makes resident cry a couple times a week with what [Caregiver G] says	N 355		

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to [him/her] and does. [Director E] asked [Resident 6] what [s/he] meant by that. [Resident 6] stated that [s/he] yells at [him/her] and makes [him/her] drink water only in the morning before [s/he] can have anything else. [Resident 6] also stated that [Caregiver G] will tell [him/her] [s/he] is lazy, eats to much and just sits in the chair, sleeps and watches TV.
[Director E] asked [Resident 6's] care team [managed care organization (MCO) Care Manager (CM) H and MCO Registered Nurse (RN) I] if [Resident 6] had a fluid restriction. [CM H] stated that there is no fluid restriction in place and [Resident 6] could drink anything [s/he] would like when [s/he] likes. [CM H] did back up [Resident 6's] accusations as [Caregiver G] use to complain to [CM H] that [Resident 6] is lazy and just sits in the chair and that [s/he] eats too much. [CM H] did tell [Resident 6] that it was [Resident 6's] right to do those things."
"03/27/2024 [Director E] has noticed [Caregiver G] put up chocolate that another resident put out for everyone to have and stated that [Resident 6] cannot have those because [s/he] is diabetic and [s/he] will eat it all. [Director E] stated to [Caregiver G] that we cannot take things away, we can advise and redirect but at the end of it, it is [Resident 6's] decision. [Director E] interviewed [Resident 2]. [Resident 2] stated that [Caregiver G] will make [Resident 6] cry several times a week. [Resident 2] stated that [Caregiver G] will only give water in the morning to [Resident 6] before giving [him/her] anything else to drink even when [Resident 6] asks for something else to drink. [Resident 2] also stated that [Caregiver G] will yell at all residents and have a rude tone of voice. [Director E] ask what [Caregiver G] would yell or be rude about. [Resident 2] stated that [Caregiver G] yelled at [Resident 6] for eating too much food. [Resident 2] also stated that

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N 355	Continued From page 14 [Caregiver G] yelled at [Resident 2] for being in the kitchen because [Caregiver G] was in the kitchen and also yelled at [Resident 2] about changing what was on the menu and the same day 04/18/2024 [Resident 2] asked [Director E] if the menu could be changed. [Director E] stated that the menu was not set in stone and if there was something that [Resident 2] would like to have that day, that [s/he] could absolutely have it and just to have any staff cross out what the original meal was and to put what the new meal would be." "On 04/17/2024 [Caregiver J] gave [Resident 6] coffee for breakfast and [Caregiver G] went and took the coffee away and told [Resident 6] in a rude tone of voice that [Resident 6] knows that [his/her] water needs to be drank first before getting any coffee or juice. [Caregiver J] stated that [Resident 6] started to cry. [Caregiver J] stated that [Resident 6] asks question and [Caregiver G] replied with a rude and irritated voice telling [Resident 6] that [Caregiver G] already answered [Resident 6] questions five times. [Caregiver J] stated that [Resident 6] instantly got a sad and depressed look, went and sat down and did not talk anyone the rest of the 7a-3p shift." "04/19/2024 [Caregiver J] was interviewed. [Caregiver J] started on 04/15/2024. [Caregiver G] was training [Caregiver J], Tuesday, Wednesday, and Thursday. [Caregiver J] stated that [Caregiver G] can only have water in the morning before anything else. [sic: Resident 6] [Caregiver J] asked [Caregiver G] the reasoning for that. [Caregiver G] stated "because [s/he] needs to drink water.' [Caregiver J] stated that [Caregiver G] only gives [Resident 6] half glass of anything. [Caregiver G] will give [him/her] because [s/he] feels that it will just sit in the cup and go to waste."	N 355		

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N 355	Continued From page 15 On 06/20/2024, at approximately 12:45 PM, Surveyor interviewed Caregiver J, while observing Resident 2 slice vegetables for homemade pizza s/he was making the residents for his/her birthday dinner. Caregiver J stated residents were encouraged to participate in the preparation of meals and to share suggestions for the menu. Resident 2 stated s/he liked to cook. On 06/20/2024, at approximately 1:00 PM, Surveyor interviewed Director E. Director E stated s/he had informed Caregiver G that a formal investigation had to be completed due to the concerns that Resident 6 and Resident 2 had brought forward. Caregiver G resigned immediately. Surveyor asked if Director E had submitted a concern the Office of Caregiver Quality regarding Caregiver G's alleged misconduct. Director E stated s/he was not aware that s/he should have done that since Caregiver G quit.	N 355		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission.	N 381		

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N 381	Continued From page 16 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an assessment of 2 of 2 resident's physical and mental condition was completed when there was a change in needs. Resident 2 sustained falls on 02/10/2024 and 04/30/2024 and a fall assessment was not completed. Resident 4 sustained falls on 01/14/2024, 02/19/2024, 04/05/2024, 04/20/2024, and 05/22/2024 and a fall assessment was not completed. Findings include: The provider is licensed to care for a maximum of 8 residents from client groups Advanced Aged, Irreversible Dementia/Alzheimer's, Terminally Ill, Developmentally Disabled, and Physically Disabled. Example 1: Resident 2 On 06/20/2024, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility, 11/16/2022, with diagnoses including obesity, difficulty in walking, edema, and Type 2 diabetes. Resident 2's record contained the following "Provider Incident Report Form" which documented: 02/10/2024: [S/he] was on toilet and lost consciousness. [S/he] fell off toilet and hit [his/her] head on toilet and fell to the floor. [S/he] said [his/her] back and knee hurt as well. [S/he]	N 381		

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N 381	Continued From page 17	N 381		

was using toilet. Staff was in the office 10 feet away waiting for [him/her] to finish. ... Heard [him/her] fall. Went in and checked on [him/her]. Then called 911 right away.
04/30/2024: Was walking back to wheelchair from bathroom. [Resident 2] said [his/her] leg gave out and fell hit [his/her] head on dresser scraped [his/her] foot. Staff was about to start meds when heard a yell and sounded like someone fell. Staff ran down there right away. Staff was asking [him/her] if [s/he] was ok. [S/he] wasn't responding at first.

Resident 2's record did not contain any fall assessments.

On 06/26/2024 at 10:03 AM, Surveyor emailed Licensee A and Director E to verify if Resident 2 had a completed fall assessment. Director E asked for clarification on what is considered a fall risk assessment.

As of 07/01/2024 at 4:00 PM, Surveyor did not receive any additional documentation.

Example 2: Resident 4

Resident 4 was admitted to the facility, 10/26/2023, with diagnosis including seizures.

Resident 4's record contained the following "Provider Incident Report Form" which documented:
01/14/2024: Came out and told staff [s/he] had fallen out of bed because [his/her] feet were tangled in [his/her] blanket ... had no marks or bruises.
02/19/2024: Fall in hallway on way to bathroom. Cut/gash above right eyebrow. Had auras before ambulance arrived. Never lost consciousness.

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N 381	Continued From page 18 [Resident 4] had been sleeping and gotten up to use the bathroom when incident occurred. 04/05/2024: Resident had an unwitnessed fall due to seizures. TV (television) fell on [his/her] back from the dresser. 04/20/2024: Had an aura and lost [his/her] balance causing [him/her] to fall. Staff heard a noise and ran down hallway to [Resident 4's] room. Found resident on floor in front of [his/her] closet. Staff helped resident on to bed ... resident had red mark on upper back, was coherent. Then staff asked resident if [s/he] was ok. [S/he] stated [s/he] was. Staff then asked resident to stay on [his/her] bed while staff contacted [his/her] guardian. While calling guardian, resident had gotten up off bed to reach for [his/her] iPad, which resident then had a 2nd aura and fallen again. Staff ran from office to resident's room and helped [him/her] onto bed a second time. Staff lifted resident's shirt to find another larger red darker mark below first red mark on upper back from first fall. Staff then stayed in room with resident while calling 911 for assistance. Resident was complaining of lower back pain from second fall. Fall in front of paramedics while still sitting on [his/her] bed. This time resident seemed confused. 05/22/2024: Came into the office told staff [names] [s/he] had an aura ... [Resident 4] got to [his/her] room, staff and [Director E] heard [him/her] fell. [Director E] went into the room, asked staff to call 911. Director went to get BP (blood pressure) cuff, [Resident 4] fell again, unwitnessed hit movie shelf, staff helps [Resident 4] to [his/her] bed. Resident 4's record did not contain any fall assessments. On 06/26/2024 at 10:03 AM, Surveyor emailed	N 381		

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N 381	Continued From page 19 Licensee A and Director E to verify if Resident 4 had a completed fall assessment. Director E asked for clarification on what is considered a fall risk assessment. As of 07/01/2024 at 4:00 PM, Surveyor did not receive any additional documentation. Cross Reference: N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes Cross Reference: N0165 DHS Reporting Incidents With Serious Injury	N 381		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not prepare and implement a temporary service plan for 1 of 1 resident (Resident 3) upon admission. Findings include: On 06/20/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on 03/01/2024 and his/her record did not contain a temporary service plan upon admission. On 06/20/2024, at approximately 1:30 PM, Surveyor interviewed Director E. Director E	N 385		

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N 385	Continued From page 20 stated s/he had been with the provider for approximately 2 months and could not provide an explanation why Resident 3's record did not contain a temporary service plan upon admission.	N 385		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not develop a comprehensive individual service plan (ISP) for 1 of 1 resident (Resident 3). Findings include: On 06/20/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility, 03/01/2024, with diagnoses including diabetes and depression.	N 386		

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N 386	Continued From page 21 Resident 3's ISP, dated 03/01/2024, had not been individualized and all identified areas were blank. On 06/20/2024, at approximately 1:30 PM, Surveyor interviewed Director E. Director E stated s/he had been with the provider for approximately 2 months and could not provide an explanation why Resident 3's ISP had not been completed.	N 386		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident's Individual Service Plan (ISP) was signed by the resident or resident's legal representative and the provider	N 387		

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N 387	Continued From page 22 acknowledging their involvement in, understanding of, and in agreement with the plan for 1 of 3 resident records reviewed (Resident 5). Findings include: On 06/20/2024, Surveyor reviewed Resident 5's record. Resident 5 admitted to the facility on 07/20/2021, is his/her own person and is represented by a managed care organization (MCO) care manager. Resident 5's ISP, dated 01/01/2024, was only signed by previous House Manager C. On 06/20/2024, at approximately 1:30 PM, Surveyor interviewed Director E. Director E stated s/he had been with the provider for approximately 2 months and could not provide an explanation why resident ISPs were not signed by the resident representatives.	N 387		
{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.	{N 389}		

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{N 389}	Continued From page 23 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the Individual Service Plan (ISP) was updated when there was a change in needs and physical or mental condition for 2 out of 3 residents. This is a repeat deficiency. See Statement of Deficiency (SOD) UK3M11, dated 09/11/2023. Resident 4's ISP was not updated to include s/he experienced seizures and auras which resulted in falls and guidelines for caregivers and displayed toileting behaviors. Resident 5's ISP was not updated to include his/her behaviors towards residents and staff and guidelines for caregivers. Findings include: The provider is licensed to provide services for up to 8 residents in the client groups: advanced aged, irreversible dementia/Alzheimer's, physically disabled, developmentally disabled, emotionally disturbed/mental illness, and terminally ill. On 06/20/2024, Surveyor reviewed Resident 4's and Resident 5's record. Example 1: Resident 4 Resident 4 was admitted to the facility, 10/26/2023, with diagnosis including seizures. Resident 4's observation notes, dated 02/16/2024 to 06/17/2024, documented:	{N 389}		

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{N 389}	Continued From page 24 02/16/2024: Had an aura at 5:25 PM (monitored until end of shift) 02/18/2024: Had a fall on way to bathroom approximately 12:45AM in hallway - [S/he] was conscious & alert until having 4 auras after fall - [S/he] would become quiet & looked lost. 02/19/2024: Began to have a seizure around 6:15AM. [S/he] woke up around 6:10 AM to use the restroom. [S/he] told staff [s/he] wasn't feeling well and went into [his/her] bedroom to help [him/her] with [his/her] socks and shoes. [S/he] told staff that [s/he] was seeing auras. Shortly after [his/her] shoes were on, [s/he] began to have a seizure. [S/he] rolled onto [his/her] back and then to the right several times. 04/01/2024: Had an aura at 6:24 PM. Staff continued to monitor during shift. 04/02/2024: Auras at 5:20 PM & 5:45 PM 04/03/2024: Aura at 4:30 PM (continued to monitor during shift) 04/09/2024: Auras at 4:15 PM & 8:45 PM. Staff monitored/checked on [him/her] every hour 04/15/2024: Had an aura 7:25 PM. Staff monitored [him/her] during rest of shift 04/20/2024: Had 2 falls in bedroom within minutes of one another. Staff was there to assist after both falls due to auras. See Incident Report. Was taken by ambulance to hospital for observation 5:00 PM 04/24/2024: Had aura at 5:40 PM. Staff continued to monitor during shift. 04/25/2024: Aura at 3:25 PM and 8:45 PM. Staff continued to monitor throughout shift. 04/27/2024: Aura at 12:45 AM 04/29/2024: Had an aura around 7:20 AM. I continued to monitor. 04/30/2024: Had an aura around 7:20 AM. We conti9nued to monitor. Had aura at 3:43 Pm and 8:35 PM. Staff monitored the whole shift. 05/01/2024: Had an aura @ 7:40. I continued	{N 389}		

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monitoring.
05/02/2024: Had an aura @ 7:30 AM.
05/04/2024: Had an aura @ 2:45 PM. Continued to monitor [him/her]
05/05/2024: Had an aura @ 7:30 AM. Staff continued to monitor rest of shift. Had an aura @ 3:30 PM when passing meds. Monitored, symptoms lessened.
05/06/2024: Had an aura around 7:30 AM. Continued to monitor.
05/07/2024: Had an ora [sic: aura] around 9:30 PM.
05/08/2024: Had an aura @ 7:30 AM. Continued to monitor but seemed fine after 1 hr (hour). Had an aura at 3:42 PM & 7:11 PM. Staff monitored whole shift.
05/09/2024: Had an aura @ 7:30 AM + 11 Continued to monitor after but seem to be doing good. Had an aura at 4:33 PM. Continued to monitor throughout shift.
05/14/2024: Had an aura at 7:15 AM. Monitored [him/her] for several hours. Had an aura at 7:04 PM. Staff continued to monitor.
05/15/2024: Had an aura at 7:30 AM. We continued monitoring. Had an aura at 5:22 PM. Staff continued to monitor rest of shift.
05/17/2024: Had an aura at the table @ 7:15 AM. [S/he] let staff know that [s/he] was ok.
05/18/2024: Had a aura around 8:00 AM, doing well.
05/21/2024: Had an aura @ 7:10 in the bathroom. Monitor after seems to be doing good.
05/22/2024: Had an aura @ 7:30. We monitored after seems to be ok.
05/27/2024: Had aura @ 7:15 AM and 1:30 PM. Checked on frequently.
05/29/2024: Had 4-5 seizure like synptoms, gave nasal spray was done. [S/he] was ok after 10 mins (minutes)
05/30/2024: Had a oura [sic: aura] at 7:40 [S/he]

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said [s/he] was good [s/he] went in [his/her] room and watched movies.
06/03/2024: Had an aura @ 7:40 AM was good after. Went with [mom/father]. Keeps peeing on the bathroom floor.
06/04/2024: Peed all over floor while waiting in BR (bathroom) for shower. Stepped all in it w/no (with no) shoes on. Had to mop 4X (4 times) during shift b/c (because) of this. Informed [him/her] that if [s/he] makes an accident on floor [s/he] needs to tell staff and not just leave it.
06/11/2024: Had an aura @ 5:30 PM. Was showered; will need to be checked when going to the bathroom to make sure [s/he's] wiping properly. Had feces all over [his/her] robe.
06/12/2024: Had an aura @ 1:30 PM. Came and told staff, [s/he] look confused but came to after awhile
06/13/2024: Peed all over laundry room bathroom. Had an aura @ 9:30
06/17/2024: Had an aura @ 8:30 when walking to room so [s/he] sat in chair until [s/he] was good.

Resident 4's ISP, dated 11/04/2023, did not document or provide caregiver guidelines regarding Resident 4's diagnoses, that s/he experienced seizures, that s/he was a fall risk and that s/he displayed toileting behaviors.

Example 2: Resident 5

Resident 5 was admitted to the facility 07/20/2021.

Resident 5's observation notes, dated 02/16/2024 to 04/27/2024, documented:
02/16/2024: Very rude and bossy
02/17/2024: Did not give [his/her] BS (blood sugar) levels or oxygen percentage to staff.

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{N 389}	Continued From page 27 [S/he] was very 'short' and had a few choice things to say 02/18/2024: Was distant but came out for dinner/snack and meds. 03/22/2024: Had bad behaviors at dinner time (in front of all residents. Once again aimed at staff.) Again at night med pass. Unacceptable behavior. 04/04/2024: Gave PM Meds & insulin ... [s/he] ignored repeated requests to give staff [his/her] PM insulin pen (took it to [his/her] room). 04/14/2024: Same as always. 04/15/2024: Grumpy but quiet. Slammed bedroom door after both med passes. 04/21/2024: Moody and quiet (told staff & residents [s/he] didn't want me here for my shift on [his/her] birthday). 04/27/2024: More negative, unprovoked bad behaviors/attitude towards staff. Resident 5's ISP, dated 01/01/2023 and 01/01/2024, signed by previous House Manager C, documented no behaviors. On 06/20/2024, at approximately 1:30 PM, Surveyor interviewed Director E. Director E stated s/he had been with the provider for approximately 2 months and could not provide an explanation why resident ISPs were not individualized. Director E stated s/he was in the process of reviewing all resident ISPs.	{N 389}		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur	N 404		

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N 404	Continued From page 28 within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an onsite review of the CBRF's (Community-Based Residential Facility) medication administration and medication storage systems were completed in 2023 by a physician, pharmacist, or registered nurse (RN). This is a repeat deficiency. See Statement of Deficiency (SOD) BYVS11, dated 08/31/2022. Findings include: On 06/20/2024, at approximately 12:30 PM, Surveyor requested the providers medication audit from Director E for 2023. Director E stated s/he was unable to locate documentation that this audit had been completed. As of 07/01/2024 at 4:00 PM, Surveyor did not receive any additional documentation.	N 404		

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N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure proper documentation on the Medication Administration Record (MAR) for 3 of 4 residents reviewed. Resident 2's, Resident 3's, and Resident 5's MARs contained blank marks where staff initials should have been recorded to document medication administration. Findings include: On 03/05/2024 and 05/21/2024, the Department received a concern alleging that staff are not trained in med administration. On 06/20/2024, Surveyor reviewed Resident 2's, Resident 3's, and Resident 5's record. Example 1: Resident 2	N 415		

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N 415	Continued From page 30 Resident 2 was admitted to the facility on 11/16/2022. Resident 2's February 2024 MAR did not document the following medication administrations: 02/11 - Bupropion, Famotidine, Fluoxetine 20 MG, Levothyroxine, Methylcellulose Powder, Polyethylene Glycol, Vitamin D, Metoprolol Tartrate, Calcium Acetate, Diclofenac Sodium 02/12 - Fluoxetine 40 MG, Isosorbide, 02/13 - Bupropion, Famotidine, Fluoxetine 20 MG, Levothyroxine, Methylcellulose Powder, Polyethylene Glycol, Vitamin D, Metoprolol Tartrate, Calcium Acetate, Diclofenac Sodium Resident 2's March 2024 MAR did not document the following medication administrations: 03/04, 03/05 and 03/06 - Bupropion, Famotidine, Finasteride, Fluoxetine 20 MG, Fluoxetine 40 MG, Isosorbide, Levothyroxine, Methylcellulose Powder, Polyethylene Glycol, Tamsulosin, Vitamin D 03/04, 03/05, 03/06, and 03/07 - Warfarin Sodium, Gabapentin, Trazadone, Metoprolol Tartrate, Calcium Acetate, Diclofenac Sodium Resident 2's April 2024 MAR did not document the following medication administrations: 04/02 and 04/03 - Gabapentin, Tamsulosin, Warfarin Sodium, Trazadone, Diclofenac Sodium 04/01, 04/02 and 04/03 - Bupropion, Famotidine, Finasteride, Fluoxetine 20 MG, Fluoxetine 40 MG, Isosorbide, Methylcellulose Powder, Polyethylene Glycol, Vitamin D, Metoprolol Tartrate, Calcium Acetate Linzess - Take 1 capsule by mouth every other day on EVEN DAYS of the year. Documented as administered 04/04/2024 through 04/08/2024.	N 415		

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N 415	Continued From page 31 Not documented as administered on 04/22, 04/26, and 04/30. Example 2: Resident 3 Resident 3 was admitted to the facility on 03/01/2024. Resident 3's April 2024 MAR did not document the following medication administrations: 04/01, 04/02, and 04/03 - Atorvastatin, Clopidogrel, Semglee (insulin), Spironolactone, Venlafaxine, Insulin Aspart 04/01, 04/02, 04/03, and 04/04 - Ferrous Gluconate, Vitamin D3, Acetaminophen 04/02, 04/03, 04/04, and 04/05 - Gabapentin Example 3: Resident 5 Resident 5 was admitted to the facility on 07/20/2021. Resident 5's March 2024 MAR did not document the following medication administrations: 03/04, 03/05, and 03/06 - Amlodipine, aspirin, Atorvastatin, Bupropion, Cetirizine, Clindamycin, Duloxetine, Furosemide, Jardiance, Metoprolol, Oxybutynin, Polyethylene glycol, Tamsulosin, Fiber Laxative, Fluticasone, Ipratropium, Lantus Solostar, Symbicort Resident 5's April 2024 MAR did not document the following medication administrations: 04/01, 04/02, 04/03, 04/04, and 04/05 - Amlodipine, 04/01, 04/02, and 04/03 - aspirin, Bupropion, Cetirizine, Duloxetine, Furosemide, Jardiance, Metoprolol, Oxybutynin, Polyethylene glycol, Tamsulosin, Fiber Laxative, Fluticasone, Ipratropium, Lantus Solostar, Symbicort	N 415		

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N 415	Continued From page 32 04/02 and 04/03 - Atorvastatin On 06/20/2024, at approximately 1:30 PM, Surveyor interviewed Director E. Director E stated s/he had been with the provider for approximately 2 months and had been working with staff on proper medication administration documentation.	N 415		
N 416	83.37(2)(e) Other administration given or delegated by RN Other administration. Injectables, nebulizers, stomal and enteral medications, and medications, treatments or preparations delivered vaginally or rectally shall be administered by a registered nurse or by a licensed practical nurse within the scope of their license. Medication administration described under sub. (2)(e) may be delegated to non-licensed employees pursuant to s. N 6.03(3). This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure injectables administered by 1 of 1 caregiver reviewed was delegated by a registered nurse (RN) within the scope of their practice. Caregiver F administered insulin to Resident 5 without nurse delegation. Findings include: On 03/05/2024, the Department received a concern alleging that staff are not trained in medication administration. On 05/21/2024, the Department received a concern alleging that staff were passing	N 416		

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N 416	Continued From page 33	N 416		

medications without having certification including administering injections.

The provider is licensed to care for a maximum of 8 residents from client groups Advanced Aged, Irreversible Dementia/Alzheimer's, Terminally Ill, Developmentally Disabled, and Physically Disabled.

According to s. N 6.03(3), SUPERVISION AND DIRECTION OF DELEGATED ACTS.
In the supervision and direction of delegated acts an RN shall do all of the following:
(a) Delegate tasks commensurate with educational preparation and demonstrated abilities of the person supervised.
(b) Provide direction and assistance to those supervised.
(c) Observe and monitor the activities of those supervised.
(d) Evaluate the effectiveness of acts performed under supervision.

On 06/20/2024, Surveyor reviewed Caregiver F's record.
Caregiver F was hired prior to 02/2024.
Caregiver F's "Wisconsin Community-Based Care and Treatment Training Registry" documented that s/he completed medication administration training on 04/24/2024.

On 06/20/2024, Surveyor reviewed Resident 5's record.

Resident 5 was admitted to the facility, 07/13/2021, with diagnoses including Type 2 diabetes.

Resident 5's March 2024 Medication Administration Record documented:

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N 416	Continued From page 34 Lantus Solostar (insulin) Inject 16 units subcutaneously in the morning and 36 units at bedtime. Resident 5's April 2024 Medication Administration Record documented: Lantus Solostar (insulin) Inject 16 units subcutaneously in the morning and 36 units at bedtime. Novolog Flexpen (insulin) Inject 15 unites subcutaneously 3 times daily before meals plus siding scale. Caregiver F administered Resident 5's Lantus Solostar 29 times in March and April 2024. Caregiver F administered Resident 5's Novolog 15 times in April 2024. On 06/20/2024, at approximately 1:00 PM, Surveyor requested Caregiver F's RN delegation. Director E reviewed Caregiver F's file and was unable to provide documentation showing that Caregiver F had received RN delegation. As of 07/01/2024 at 4:00 PM, Surveyor did not receive any additional documentation. Cross Reference: N0239 83.20(2)(a)-(d) Department-Approved Training Courses	N 416		
{N 454}	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if	{N 454}		

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{N 454}	Continued From page 35	{N 454}		

any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required

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{N 454}	Continued From page 36 which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview, the provider did not maintain a record of 1 of 1 resident's (Resident 4) medical history and urgent care visit summary following medical treatment. This is a repeat deficiency. See Statement of Deficiency (SOD) UK3M11, dated 09/11/2023. Findings include: On 03/05/2024, the Department received a concern that residents were sustaining falls resulting in hospitalization. On 06/20/2024, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the facility, 10/26/2023, with diagnosis including seizures. Resident 4's record contained the following "Provider Incident Report Form" which	{N 454}		

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{N 454}	Continued From page 37 documented: 02/19/2024: Fall in hallway on way to bathroom. Cut/gash above right eyebrow. Had auras before ambulance arrived. Never lost consciousness. [Resident 4] had been sleeping and gotten up to use the bathroom when incident occurred. 04/20/2024: Had an aura and lost [his/her] balance causing [him/her] to fall. Staff heard a noise and ran down hallway to [Resident 4's] room. Found resident on floor in front of [his/her] closet. Staff helped resident on to bed ... resident had red mark on upper back, was coherent. Then staff asked resident if [s/he] was ok. [S/he] stated [s/he] was. Staff then asked resident to stay on [his/her] bed while staff contacted [his/her] guardian. While calling guardian, resident had gotten up off bed to reach for [his/her] iPad, which resident then had a 2nd aura and fallen again. Staff ran from office to resident's room and helped [him/her] onto bed a second time. Staff lifted resident's shirt to find another larger red darker mark below first red mark on upper back from first fall. Staff then stayed in room with resident while calling 911 for assistance. Resident was complaining of lower back pain from second fall. Fall in front of paramedics while still sitting on [his/her] bed. This time resident seemed confused. On 06/20/2024, Surveyor was unable to locate any medical documentation in Resident 4's record. On 06/26/2024 at 10:14 AM, Surveyor emailed Licensee A and Director E requesting Resident 4's 2024 medical documentation. Surveyor was forwarded medical documentation for an incident that occurred on 05/22/2024. As of 07/01/2024 at 4:00 PM, Surveyor did not	{N 454}		

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{N 454}	Continued From page 38 receive any additional documentation.	{N 454}		
N 538	83.48(3)(a) Fire detection systems inspected annually. After the first year following installation, fire detection systems shall be inspected, cleaned and tested annually by certified or trained and qualified personnel in accordance with the specifications in NFPA 72 and the manufacturer ' s specifications and procedures. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the smoke and heat detection systems were inspected, cleaned, and tested annually by certified or trained and qualified personnel in accordance with specifications in NFPA 72 and the manufacturer's specifications in 2023. Findings include: The provider is licensed to care for a maximum of 8 residents from client groups Advanced Aged, Irreversible Dementia/Alzheimer's, Terminally Ill, Developmentally Disabled, and Physically Disabled. 06/20/2024, Surveyor reviewed the provider's life safety reports. There were no inspection reports to indicate the smoke and heat detectors were inspected, cleaned, and tested annually in 2023 by a certified or trained and qualified personnel. On 06/20/2024, at approximately 1:30 PM, Surveyor interviewed Director E. Director E stated s/he had been with the provider for approximately 2 months and could not provide an	N 538		

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N 538	Continued From page 39 explanation the smoke detection system had not been inspected in 2023. Director E stated s/he would follow up with Licensee A. On 06/25/2024 at 5:02 PM, Surveyor emailed Licensee A and Director E requesting the 2023 smoke detection system inspection. As of 07/01/2024 at 4:00 PM, Surveyor did not receive any additional documentation.	N 538		
N 539	83.48(3)(b) Sensitivity testing performed Sensitivity testing shall be performed at intervals in accordance with NFPA 72. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the smoke and heat detection system had sensitivity testing for each device performed at intervals in accordance with NFPA (National Fire Alarm and Signaling Code) 72 requirements. Findings include: 06/20/2024, Surveyor reviewed the provider's life safety reports. Surveyor was unable to determine if the provider had an acceptable sensitivity testing completed in the last five years. On 06/20/2024, at approximately 1:30 PM, Surveyor interviewed Director E. Director E stated s/he had been with the provider for approximately 2 months and could not provide the sensitivity testing documentation. Director E stated s/he would follow up with Licensee A. On 06/25/2024 at 5:02 PM, Surveyor emailed	N 539		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017158	A. BUILDING: _____ B. WING _____	R-C 07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALICE & LOUISES II	8679 STATE HWY 186 ARPIN, WI 54410

(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 539	Continued From page 40 Licensee A and Director E requesting the most recent sensitivity testing report. As of 07/01/2024 at 4:00 PM, Surveyor did not receive any additional documentation.	N 539		