STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018895	A. BUILDING: _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI CARES GREENFIELD	3826 SOUTH 36TH STREET GREENFIELD, WI 53221

(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 06/12/2024 with information gathered through 06/19/2024, Surveyors conducted a standard survey and complaint investigation at Chi Cares Greenfield, a Community-Based Residential Facility (CBRF) in Greenfield, WI. Eleven deficiencies identified. Complaint substantiated. Census: 5	N 000		
N 159	83.12(2)(b) Non-caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Non-caregiver or resident. When there is an allegation of abuse or neglect of a resident, or misappropriation of property by a non-caregiver or resident, the CBRF shall follow the elder abuse reporting requirements under s. 46.90 Stats., or the adult at risk requirements under s. 55.043, Stats., whichever is applicable. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not investigate when there was an allegation of misappropriation of 1 of 1 resident's (Resident 1) property by another resident. Findings include: On 06/12/2024, Surveyors reviewed Resident 1's incident reports and identified the following:	N 159		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018895	A. BUILDING: _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI CARES GREENFIELD	3826 SOUTH 36TH STREET GREENFIELD, WI 53221

(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 159	Continued From page 1 Incident report dated 05/17/2024 at 12:13 PM stated the following: -"Incident Classification: Behavior- Resident to Resident altercation. Briefly Describe What Occurred: On 05/12/2024 [Resident 1] was noted to be hyperverbal, pacing and accusing [his/her] peer [Resident 2] of stealing [his/her] money, cigarettes. Staff on duty asked [Resident 1] to stop accusing [his/her] peer and had [him/her] sit far away from [Resident 2] and continued cooking for the residents. Within minutes, [Resident 1] ran over to [Resident 2] to attack [him/her]. [Resident 2] pushed [him/her] back and against the dining table. [Resident 1] sustained some bruises on [his/her] lower back but no open wounds. [S/he] denied pain then but later asked for Tylenol for pain." On 06/12/2024 at 9:45 AM, Surveyors interviewed Caregiver C. Caregiver C stated this has happened before in August 2023, too. Caregiver C stated Resident 2 had a history of stealing Resident 1's money and cigarettes. Caregiver C stated Resident 1's family would give Resident 1 money for him/her to have and to buy cigarettes. Caregiver C stated the facility has advised Resident 1's family not to give him/her money to keep at the facility. Surveyor asked Caregiver C if there was an investigation completed due to Resident 2 stealing Resident 1's cigarettes and money. Caregiver C stated, "no" because Resident 1 had moved to a different home now.	N 159		
N 189	83.13(3)(b) Post house rules, resident rights, grievances The CBRF shall post all of the following: House rules, resident rights and grievance procedures	N 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018895	A. BUILDING: _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI CARES GREENFIELD	3826 SOUTH 36TH STREET GREENFIELD, WI 53221

(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 189	Continued From page 2 as required under s. DHS 83.32(2) (b). This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure grievance procedures were posted in the facility. Findings include: On 06/12/2024 at approximately 10:00 AM, Surveyors toured the provider's facility. Surveyor was unable to locate a posting of the provider's grievance procedure. On 06/12/2024 at approximately 10:15 AM, Surveyors interviewed Caregiver B. Caregiver B stated s/he was not sure why it is not posted. Caregiver B stated s/he would let Licensee A know a copy needed to be posted.	N 189		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes.	N 220		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018895	A. BUILDING: _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI CARES GREENFIELD	3826 SOUTH 36TH STREET GREENFIELD, WI 53221

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 220	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating 1 of 2 employees reviewed had been screened for clinically apparent communicable disease including tuberculosis (TB). Caregiver C did not have a screening or TB skin test within 90 days before the start of employment. Findings include: On 06/12/2024, Surveyors reviewed Caregiver C's record. Caregiver C was hired on 03/04/2024. Caregiver C's record did not contain a communicable disease screening or TB test. On 06/12/2024 at approximately 11:00 AM, Surveyors interviewed Caregiver C. Caregiver C stated s/he had not had a TB skin test since s/he had been hired. On 06/12/2024 at approximately 1:06 PM, Surveyors interviewed Licensee A. Licensee A stated Caregiver C had been sent home and s/he is not to return to work until s/he got his/her TB test done.	N 220		
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	N 302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018895	A. BUILDING: _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI CARES GREENFIELD	3826 SOUTH 36TH STREET GREENFIELD, WI 53221

(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 302	Continued From page 4 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 1 of 2 residents reviewed (Resident 2) was screened for clinically apparent communicable disease, including tuberculosis (TB), by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse within 90 days before or 7 days after admission. Findings include: On 06/12/2024, Surveyor reviewed resident records and identified the following: Resident 2 was admitted on 12/15/2021. The documents provided to Surveyor from Resident 2's record did not contain the results of a TB test and a statement showing Resident 2 was free of communicable disease. On 06/12/2024 at 12:00 PM, Surveyor requested TB test and statement showing Resident 2 as free of communicable disease from Licensee A. On 06/12/2024 at 1:06 PM, Surveyor interviewed Licensee A. Licensee A stated s/he could not find evidence Resident 2 was screened for TB within 90 days before or 7 days after admission.	N 302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018895	A. BUILDING: _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI CARES GREENFIELD	3826 SOUTH 36TH STREET GREENFIELD, WI 53221

(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 302	Continued From page 5 Licensee A stated Resident 2 was already living at the facility prior to the change of ownership but Resident 2 recently had labs drawn for his/her TB skin test and would send them when s/he received them.	N 302		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not assess 2 of 2 residents (Resident 1 and Resident 2) reviewed for resident's needs, abilities, and physical and mental condition before admitting the person to the facility. There was no evidence of a completed assessment for Resident 1 and Resident 2 when there were physical altercations between both residents and Resident 1 sustained injuries. Findings include: The facility is licensed as a Class CNA (non-ambulatory) facility for 7 residents with	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018895	A. BUILDING: _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI CARES GREENFIELD	3826 SOUTH 36TH STREET GREENFIELD, WI 53221

(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 381	Continued From page 6	N 381		

programs in emotionally disturbed/mental illness, developmentally disabled, physically disabled, advanced age and traumatic brain injury.

On 06/12/2024, Surveyors reviewed Resident 1's and Resident 2's records and identified the following:

Resident 1
Resident 1 was admitted to the facility on 12/15/2021.
Resident 1 had the following incident reports:
-"08/26/2023 at 4:00 PM: Incident Classification: Behavior - Resident to Resident Altercation. Briefly Describe What Occurred: On 05/12/2024 [Resident 1] was noted to be hyperverbal, pacing and accusing [his/her] peer [Resident 2] of stealing [his/her] money, cigarettes. Staff on duty asked [Resident 1] to stop accusing [his/her] peer and had [him/her] sit far away from [Resident 2] and continued cooking for the residents. Within minutes, [Resident 1] ran over to [Resident 2] to attack [him/her]. [Resident 2] pushed [him/her] back and against the dining table. [Resident 1] sustained some bruises on [his/her] lower back but no open wounds. [S/he] denied pain then but later asked for Tylenol for pain."

-"08/26/2023 at 10:19 PM: Incident Classification: Behavior-Resident to Resident Altercation. Briefly Describe What Occurred: Received a phone call from the staff on duty. S/he states that [Resident 1] and one of [his/her] peers got into an altercation. [S/he] states that [s/he] separated them and later noticed that [Resident 1] has a[sic] swelling on [his/her] right arm; [s/he] asked [him/her] what happened and [s/he] said that [his/her] peer did that to [him/her] during their altercation. [S/he] gave [him/her] ice pack and had [him/her] sit down to get some rest.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018895	A. BUILDING: _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI CARES GREENFIELD	3826 SOUTH 36TH STREET GREENFIELD, WI 53221

(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 381	Continued From page 7	N 381		

Resident Statement: When I arrived at the home, [Resident 2] confirmed what the staff had told me; [s/he] stated that [his/her] peer caused [him/her] the injury
by slamming [him/her] on the staircase and 'kicked [him/her] in the groin'; [s/he] reports some discomfort in the arm but none in [his/her] legs/groin areas; [s/he] states that [his/her] peer had been taking [his/her] things.
Did injuries require outside medical care? Yes
Notes: [Resident 1] was encouraged to go to the ER for further eval. [S/he] agreed and was evaluated at SLMC ER. [S/he] was dx (diagnosed) with contusion. The affected areas wrapped up and [s/he] was discharged back to the home."

-05/17/2024 at 12:13 PM: Incident Classification: Behavior-Resident to Resident Altercation. Briefly Describe What Occurred: On 05/12/2024 [Resident 1] was noted to be hyperverbal, pacing and accusing [his/her] peer, [Resident 2] of stealing [his/her] money, cigarettes. Staff on duty asked [Resident 1] to stop accusing [his/her] peer and had [him/her] sit far away from [Resident 2] and continued cooking for the residents. Within minutes, [Resident 1] ran over to [Resident 2] to attack [him/her]. [Resident 2] pushed [him/her] back and against the dining table. [S/he] sustained some bruises on [his/her] lower back but no open wounds. [S/he]denied pain then but later asked for Tylenol for pain.

Resident 2
Resident 2 was admitted to the facility on 12/15/2021.
Resident 2 had the following incident reports:
-"08/26/2023 at 10:19 PM: Incident Classification: Behavior-Resident to Resident Altercation. Briefly Describe What Occurred:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018895	A. BUILDING: _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI CARES GREENFIELD	3826 SOUTH 36TH STREET GREENFIELD, WI 53221

(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 381	Continued From page 8	N 381		

received a phone call from the staff on duty stating that [Resident 2] and one of [his/her] peers got into an altercation. [S/he] states [s/he] separated them and later noticed that the other client has a swollen right arm but [Resident 2] has no singlmark [sic] of acute injury on [hi/her] body and required no treatment following the altercation. Resident Statement: When I arrived at the home, [Resident 2] confirmed what the staff reported. [S/he] reported that [him/her] and [his/her] peer were fighting over a TV remote, and [s/he] began to accuse [him/her] of stealing [his/her] money, cigarettes. [S/he] states that [s/he] slammed [him/her] in the staircase and kicked [him/her] in [his/her] groin; [s/he] denies any injuries to [him/herself]. Care Manager Notified? Yes 08/27/2023 09:48 AM [Resident 2]'s Care Team members notified. 30 day notice to move [Resident 2] to another home given."

05/17/2024 at 12:13 PM: Incident Classification: Behavior-Resident to Resident Altercation. Briefly Describe What Occurred: On 05/12/2024 [Resident 2] got into an altercation with another resident; [s/he] states that resident had been accusing [him/her] of stealing [hi/s/her]cigarettes and money and ran over to where [s/he] was sitting on the couch to attack [him/her]; [s/he] states that [s/he] pushed [him/her] back and against the dinning table and the care giver on duty stepped in to stop them; [s/he] denies any injury following the altercation. Care Manager Notified? Yes 05/17/2024 10:10 AM. Reminded of the importance to move client to another home."

On 06/12/2024 at approximately 10:30 AM, Surveyors interviewed Caregiver B and Caregiver C. Caregiver B stated Licensee A would be the one who would complete an assessment on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018895	A. BUILDING: _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI CARES GREENFIELD	3826 SOUTH 36TH STREET GREENFIELD, WI 53221

(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 381	Continued From page 9 Resident 1 and Resident 2 but s/he could not find them in Resident 1 or Resident 2's records. On 06/12/2024 at 12:00 PM, Surveyors requested to review any assessments completed for Resident 1 and Resident 2 from Licensee A. As of 06/12/2024 at 4:00 PM, Licensee A did not send any evidence of assessments completed for Resident 1 and Resident 2's behaviors that led to two physical altercations and injuries for Resident 1 that required being sent to the Emergency Room.	N 381		
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 and/or the	N 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018895	A. BUILDING: _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI CARES GREENFIELD	3826 SOUTH 36TH STREET GREENFIELD, WI 53221

(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 387	Continued From page 10 resident's legal representative, as appropriate, were involved in developing the individual service plan (ISP) and signed the plan acknowledging their involvement in, understanding of, and agreement with the plan for 2 of 2 resident records reviewed (Resident 1 and Resident 2). Findings include: On 06/12/2024 at approximately 1:00 PM, Surveyors reviewed the records of Resident 1 and Resident 2. Resident 1 was admitted on 12/15/2021. Resident 1's current ISP, dated 12/01/2023, was not signed or dated by Resident 1's Health Care Power of Attorney (POA). Resident 2 was admitted on 12/15/2021. Resident 2's current ISP, dated 06/18/2022, was signed by Resident 2 but not his/her guardian. On 06/19/2024 at approximately 11:10 AM, Surveyor interviewed Licensee A. Licensee A stated s/he mailed/e-mailed the documents and was waiting for the responsible parties to sign and send them back to them.	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	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018895	A. BUILDING: _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI CARES GREENFIELD	3826 SOUTH 36TH STREET GREENFIELD, WI 53221

(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 389	Continued From page 11	N 389		

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 update 1 of 2 residents' Individual Service Plans (ISP) annually. Resident 2's ISP was not updated annually in 2023 and 2024.

Findings include:

On 06/12/2024 at 10:00 AM, Surveyor reviewed Resident 2's record. Resident 2's record identified the following:
-Resident 2 was admitted on 12/15/2021.
-Resident 2 has diagnoses of diabetes type II and smoker.
-Resident 2 has a guardian.
-Resident 2's current ISP was dated 06/18/2022.

On 06/12/2024 at approximately 10:30 AM, Surveyors interviewed Caregiver B and Caregiver C. Caregiver B stated Licensee A would be the one who would complete the annual ISP updates for Resident 2. Caregiver B stated s/he could not locate Resident 2's ISPs for 2023 and 2024.

On 06/12/2024 at 1:06 PM, Surveyors requested from Licensee A a more updated ISP than 06/18/2022. As of 06/12/2024 at 4:00 PM, Surveyors did not receive evidence of an updated ISP for Resident 2. Resident 2 's most recent ISP was dated 06/18/2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018895	A. BUILDING: _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI CARES GREENFIELD	3826 SOUTH 36TH STREET GREENFIELD, WI 53221

(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 416	Continued From page 12	N 416		
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 staff interview, the provider did not administer an injectable medication by a registered nurse or a licensed practical nurse within the scope of the license. Medication administration was not delegated to non-licensed employees pursuant to s.N6.03(3) for 1 of 2 unlicensed caregivers (Caregiver C) who passed medication. Findings include: On 06/12/2024 at approximately 10:30 AM, Surveyors requested to review Caregiver C's employee records. Caregiver C was hired on 03/04/2024. Caregiver C's record did not contain evidence of nurse delegation. On 06/12/2024 at approximately 10:45 AM, Surveyors interviewed Caregiver B and Caregiver C. Caregiver B and Caregiver C indicated one resident received insulin. On 06/12/2024 at approximately 11:00 AM, Surveyors interviewed Caregiver C. Caregiver C stated s/he was only trained by Caregiver B, who was not a registered nurse, for insulin administration. Surveyors asked Caregiver C	N 416		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018895	A. BUILDING: _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI CARES GREENFIELD	3826 SOUTH 36TH STREET GREENFIELD, WI 53221

(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 416	Continued From page 13 who would be the one to delegate to Caregiver C to administer insulin. Caregiver C stated Licensee A would. Caregiver C stated Licensee A had not delegated to him/her and s/he had been administering insulin.	N 416		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018895	A. BUILDING: _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI CARES GREENFIELD	3826 SOUTH 36TH STREET GREENFIELD, WI 53221

(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 431	Continued From page 14	N 431		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 1 resident's (Resident 2) blood sugar was monitored 3 times weekly on Monday, Wednesday, and Friday at 8:00 AM for diabetes mellitus. Resident 2's blood sugar had not been checked since prior to March 2024.

Findings include:

On 06/12/2024 at 9:30 AM, Surveyors reviewed Resident 2's record. Resident 2 was admitted to the facility on 12/15/2021, with diagnoses including diabetes type II.

As of 01/01/2024, Resident 2 had a prescription for test strips to test blood glucose 3 times weekly on Monday, Wednesday, and Friday at 8:00 AM for diabetes mellitus.

Surveyors reviewed Resident 2's medication administration record (MAR) for February 2024. Staff documented Resident 2's test strips was other: not available for administration from 02/01/2024 to 02/29/2024. Resident 2 missed 12 consecutive times of his/her blood sugar being checked because the test strips were not available.

Surveyors reviewed Resident 2's medication administration record (MAR) for March 2024. Staff documented Resident 2's test strips was other: not available for administration from 03/01/2024 to 03/31/2024. Resident 2 missed 13 consecutive times of his/her blood sugar being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018895	A. BUILDING: _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI CARES GREENFIELD	3826 SOUTH 36TH STREET GREENFIELD, WI 53221

(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 431	Continued From page 15	N 431		

checked because the test strips were not available.

Surveyors reviewed Resident 2's medication administration record (MAR) for April 2024. Staff documented Resident 2's test strips was other: not available for administration from 04/01/2024 to 04/30/2024. Resident 2 missed 13 consecutive times of his/her blood sugar being checked because the test strips were not available.

Surveyors reviewed Resident 2's medication administration record (MAR) for May 2024. Staff documented Resident 2's test strips was other: not available for administration from 05/01/2024 to 05/31/2024. Resident 2 missed 14 consecutive times of his/her blood sugar being checked because the test strips were not available.

Surveyors reviewed Resident 2's medication administration record (MAR) for June 2024. Staff documented Resident 2's test strips was other: not available for administration from 06/01/2024 to 06/12/2024. Resident 2 missed 5 consecutive times of his/her blood sugar being checked because the test strips were not available.

On 06/12/2024 at approximately 10:30 AM, Surveyors interviewed Caregiver B and Caregiver C. Caregiver B stated Resident 2's insurance changed so they needed to get his/her test strips from Walgreens but Resident 2 bought the wrong strips. The test strips did not fit his/her meter so s/he had been out of supplies for months. Caregiver B stated s/he was in charge of making sure the test strips were there since s/he was the medication passer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018895	A. BUILDING: _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI CARES GREENFIELD	3826 SOUTH 36TH STREET GREENFIELD, WI 53221

(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 526	Continued From page 16	N 526		
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 conduct 1 of 2 other evacuation drills at least semi-annually for calendar year 2023. Findings include: On 06/12/2024, Surveyors requested to review other evacuation drills for calendar year 2023. There was one other evacuation drill conducted on 02/08/2023. On 06/12/2024 at approximately 10:45 AM, Surveyors interviewed Caregiver B if there were any other evacuation drills conducted in calendar year 2023. Caregiver B stated all the drills would have been in the binder. Caregiver B stated if it was not in the binder then it must have not been done. Caregiver B stated s/he was the one in charge of completing them and s/he must have missed conducting a second drill in 2023.	N 526		
N 666	83.59(7)(a) Emergency egress lighting provided All exit passageways and stairways shall be provided with emergency egress lighting with a stand-by power source. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all exit passageways were	N 666		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018895	A. BUILDING: _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHI CARES GREENFIELD	3826 SOUTH 36TH STREET GREENFIELD, WI 53221

(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 666	Continued From page 17 provided with emergency egress lighting with a stand-by-power source for 2 of 4 emergency egress lighting units on the first floor by staircase and the upstairs hall way. Findings include: On 06/12/2024 at approximately 10:00 AM, Surveyors toured the facility with Caregiver B. Surveyors tested the egress lighting on the first floor by the stair case and 2 of 2 lights did not turn on. Surveyors also tested the egress lighting on the 2nd floor in the hallway and 2 of 2 lights did not turn on. On 06/12/2024 at approximately 10:15 AM, Surveyors interviewed Caregiver B. Caregiver B stated s/he was not aware they were not working and s/he would let Licensee A know about it so s/he could get them fixed.	N 666		